2002

Chaotic patterns of restraining power: The dynamics of personal decision making in a long-term care facility

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Chaotic Patterns of Restraining Power:

The Dynamics of Personal Decision Making in a Long-Term Care Facility

by

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DISSERTATION
Submitted to the Faculty of Social Work
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partial fulfilment of the requirements
for the Doctor of Philosophy degree.

Abstract

This is a study of personal decision-making dynamics at multiple levels in an Ontario Home for the Aged, including managers, staff leaders, direct care workers, non-direct care workers and residents. Personnel dyadic units of differential decision-making power were postulated: managers/staff leaders, staff leaders/direct care workers and direct care workers/residents. Weber's bureaucracy, other organizational power literature and chaos theory provide the theoretical frame. Staff completed a self administered questionnaire package which included variants of the Staff Involvement in Decision Making scale (Kruzich, 1989), open-ended and demographic questions. Residents were assisted in completing a similar, but shorter, questionnaire. Cognitively impaired residents' decision behaviours were observed, field notes were transcribed and key informants interviewed. Quantitative analysis included descriptive analyses, correlations, T Tests and multiple regressions. While similar patterns emerged from a visual inspection of means on several demographic and decision variables across personnel groups, T Tests found no significant differences in decision scores between groups in each dyadic unit. However, there were significant differences between direct care workers and the non-direct care workers who were not represented in the care dyadic units. Multiple regression models found that staff decision-making power could be predicted by staff perception of supervisors' decision-making power (greater than 40%). Finally a fractal-like model is suggested as a tool for analysing decision-making power between dyadic units of staff in long-term care.

Dedication

This dissertation is dedicated to two older women in my life, Irene (Harrison) Loucks and Marie (Fiddis) Campbell. These two exceptional strong women have taught me the meaning of age – with its wonderful opportunities for new beginnings and its potential assaults on one's dignity and self respect.

Acknowledgements

I have not done this work in isolation. Without the help of many strong supportive individuals, I am sure I might have perished along the way. Each member of the dissertation committee, my family and my friends have offered tremendous help throughout.

The chair of the dissertation committee, Dr. Martha Laurence has been a source of abiding strength through the entire process. As a positive role model she has kept me working through the more difficult times and willingly read the earliest drafts that were almost unreadable. Her strength as a conceptual thinker, her experience in gerontology and long-term care, together with her real understanding of the disadvantage experienced by women in organizations were exceptionally helpful. Dr. Cheryl Regehr provided methodological expertise from the superb statistics and methodology courses she instructed, through my proposal plan development and data analysis. She imparted technical knowledge in a way that made statistics accessible and by the conclusion, I actually can now say I enjoy statistics and data analysis. Dr. Kim Morouney offered a unique and helpful perspective as someone who understands the complexities of organizations, and their impact on women. Her talent with language through the editing process has been irreplaceable. Dean Luke Fusco taught me about social work and power from the initial social work course he instructed many years ago, through to our discussions about Machiavelli and the power that exists in long-term care organizations. He offered a social work perspective on the ways

power reveals itself. I feel incredibly fortunate to have these four individuals on my dissertation committee; each of them is an inspiration in their unique way.

Without the support and helpful suggestions of the home administrator, managers, staff and residents in the study location, this work would not have been possible. Although I cannot identify these people for reasons of confidentiality, I will remember their helpful interventions, insightful comments and commitment to long-term care. Rick Goy was a resource particularly related to statistics; he was always willing to discuss those regression analyses one more time. Many good friends and fellow students have provided support on those occasions when things seemed to be crumbling around me.

Throughout it all, my family has been my most important resource. My partner, Al, has always been my strongest ally and supporter, and the past few years of doctoral study offer a particular example of that support. In fact, a second dissertation could be written about the ways he helped both professionally and personally, from his unyielding belief in me to proofreading, photocopying, cooking and laundry. My children and grandchildren both supported me and provided a welcome diversion after many hours at the computer. To each of these generous encouraging people — thank you.

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I: Introduction

Throughout my work with older adults, I have seen elders struggle to retain even a small vestige of the self determination they previously had. Some debated with their children the feasibility of entering a long-term care facility; others sought alternative modes of transportation when they could no longer get on and off the bus; and still others begged the nearby nurse aide to take them to the bathroom. Regardless of the identity of the other person or the environment, the older adult involved often did not relinquish decision-making power easily. These observations led to a preliminary qualitative study about the transfer of decision-making power from the old to the young (Campbell, 2001); both have inspired this dissertation. The study has produced two primary outcomes: a clarification and enhancement of my understanding of the organizational decision-making power that impacts staff and clients, and a proposed model that links staff decision-making power at each organizational level to the decisions made by elderly residents. I will now delineate the underlying rationale for the study, define possible implications for social work practice, and, finally, summarize the dissertation by chapter.

Rationale for Study

Whether our parents and grandparents live in an institutional or a community setting, many strive continually for independence. Their endeavour resonates as a poignant reminder of the importance of power and decision making, and sometimes even abuse in the lives of the elderly, regardless of the

setting. Even if elders experience a limitation of function and require assistance, they attempt to keep their personal power and self-determination in new relationships with long-term care service providers. But in this exchange of power between client and the health-care bureaucracy, differences exist between the power held by clients, the provider organization and its employees. Decisions within each relationship, between clients and employees and between clients or employees and the organization itself, reflect the personal power of the individuals involved and the power of the organization itself.

This is a study of decision making as a representation of the power that exists within the relationships in one long-term care facility. Classic concepts of power from the literature have been placed on a continuum that demonstrates the range of power definitions that extends from power over another that is overt, controlling and aggressive; through power that is overt and authoritative but not aggressive; to power that is invisible and influential (Lukes, 1974; French and Raven, 1959; Pinderhughes, 1983; & Hugman, 1991). The continuum might even be extended to include consensual power (Figure 1). Each level of power on such a continuum of control, authority, influence and consensus is played out differently in an organization, but in the end it is expressed or achieved through decision making. The scope of personal decision making one assumes and the ability to make decisions on behalf of another person are key indicators of power.

By studying the relationship and doing a simultaneous analysis of

organizational power and decision making at different levels in long-term care organizations, the opportunity exists to understand better the impact of power relations in the lives of those who are vulnerable and even powerless. In order to enhance understanding of decision-making dynamics at various levels in a

Figure 1: Continuum of Power

Control	Authority	Influence	Consensual Decision Making
Obvious power	Less obvious power	Complex, hidden	Shared power
Shown in behaviour	Non—decision making	Control of political agenda	Giving power to others
Decision making	Legitimate, expert	Influences decisions	Collaboration
Reward, coercion		Referent	
Power over		Feeling of oneness	

Uses work of Lukes, French & Raven, Pinderhughes, Hugman

long-term care facility, this work builds connections between the hands-on world of primary custodial care of the elderly, social work principles and organizational power. The prime focus of the research question stated below is on potentially differential power relations that exist between managers and staff

leaders, between staff leaders and direct care workers and between direct care workers and recipients of service.

Is there a relationship between the decision-making patterns and differentials that occur (1) in the relationships between senior managers and front line leaders, and those that occur (2) in the relationships between front line leaders and direct care and non-direct care workers, and those that occur (3) in the relationships between direct care workers and clients in long-term care facilities?

Questions about the decision autonomy of Canada's elders deserve to take centre stage in today's aging society for a number of reasons. As the population of elders has increased and will increase more over the next few years, media and taxpayers alike have turned toward demographics, health-care costs and the burden of age related dependency, sparking concern among younger people about their capacity to handle the projected rising costs (Novak, 1997).

When we then turn our focus to Canada's elders, we inevitably must begin to concentrate on women and disadvantage. A clear majority of both those who receive and those who dispense care in the long-term care institutions that exist as part of the fabric of an ageist society (Ontario Human Rights Commission, 2001; Ontario Association Social Workers, 1999a), is female. Those who assume the decisional authority that was previously the purview of

the elder also work in an atmosphere of disempowerment —women who are daughters and wives of the elderly, nurse aides, nurses, social workers, nurse managers and members of other female dominated professions (Hugman, 1991; Laurence, 1992).

Even facility CEO's may feel disempowered when considered alongside CEO's of higher profile health-care facilities like hospitals or community clinics. Anxiety about the impact of demographics and costs of aging occur within a context of organizational power and powerlessness. Questions about the dynamics of power, then, inevitably emerge where stereotypical beliefs disadvantage old women and those who care for them (Kapp, 1997; Stack, 1986). The lenses of age and gender have illuminated the path to study these multiple intersecting fields — long-term care, decision-making, organizational power and ethics.

Relevance for Social Work Practice

This study reverberates at the core of social work — where the older disadvantaged client interfaces with her/his environment. The social work foci on strengths, empowerment, self-determination and client dignity demand workers understand decision making, particularly where vulnerable groups are concerned. In a context of diminished decision-making authority where disadvantaged groups inter-relate, the primacy of client dignity, a central tenet of the Social Work Code of Ethics (Canadian Association of Social Workers, 1994) offers a backdrop to better understand the power we have over the

vulnerable adult. Social workers committed to individual clients and to the values and ethics of the profession need to understand power dynamics in social work settings serving elderly clients and also their own influence in these relationships and organizations (Browne, 1995).

Where the larger environment is one of government fiscal restraint, such as that in Ontario in 2002, the implications of advanced age, gender and institutional power are difficult to avoid. Decision making in long-term care facilities influences not only care outcomes but also career satisfaction of workers at all levels; there may be a way to make decisions differently and reduce financial and personal costs along the way.

The possible implications for elder care recipients and their providers arising from nuances in these power relations suggest those who understand power, interrelated systems and disadvantage must become involved — social workers. Social work planners, managers and direct care workers have the skills to mediate situations where families, health-care workers and elders suffer from the combined influence posed by an environment of disadvantage, advanced age and frailty, and converging relations of power. Without intervention, the potential for misuse of power threatens to undermine the older adult care recipient's well-being at tremendous cost to both elders and Canadian health care.

Social work is primarily a discipline that works within and between systems and this study does the same; it emanates from the place where

decision-making, organizational power, long-term care and disadvantage intersect. Literature salient to the point of intersection forms the base of the literature review found in Chapter II and the theoretic base in Chapter III. Decision making, the prime focus of the study, is defined here as an operationalization of organizational power. The use of chaos as a theoretical perspective proves to be a useful standpoint in working where several fields, such as those of this study, intersect. The conceptualizations of chaos proffer tools with which I illustrate my initial hypothesis and ultimately propose a new alternative model for viewing long term care decision-making power. Chaos theory and its usefulness as a frame when studying human social systems, and in particular organizational power, is described in Chapter III. These initial chapters establish a foundation for subsequent methodology, results, discussion and conclusion.

The methodology section, Chapter IV, describes the study populations, instrumentation and also the strategies of data collection. Various methods of data collection are used. Staff and some residents provide data through questionnaires while observational data are collected from residents who were unable to complete the questionnaires. Finally, key decision makers are interviewed. Interview and observation data provide depth, and explain the results of the quantitative analysis. Specific findings are accessible in Chapters V and VI. Chapter V details quantitative findings, Chapter VI, qualitative.

Chapter VII considers the findings using the theoretical perspectives

previously defined, and highlights from the relevant literature. In addition to an assessment of the relevance of findings to the original hypothesis, the discussion also examines its relationship to the main tenets of the theory of chaos. The usefulness of decision making as an operationalization of organizational power is elucidated with the emergence of a model of long-term care decision making linking the two concepts: decision processes and organizational power. Implications for social workers are defined particularly in relation to ethical principles and finally, the conclusion (Chapter VIII) suggests possible future research directions and broader societal implications.

II: Literature Review

Decision making in long-term care facilities occurs across multiple levels. The context of the facilities is one of changing demographics, diminished decision-making capacity of older adults, and differential levels of decision-making power of individual professional care givers, organizational decision makers and huge bureaucracies. This literature review gives an overview of the bodies of knowledge related to each of these contextual issues.

Demographics

Long-term care is being discussed across Canada as a pending gerontological boom threatens to increase costs of health care exponentially. By 2031, more than twenty-one percent of Canadians will be over sixty-five years of age (Statistics Canada, 1997a). By 2041, a full four percent of the population of Canada will be over 85 years, whereas this group comprised just over one percent of the total population in the late nineties. In 1996 there were more than 85,000 Canadians between 90 and 94 years of age and more than 3,000 over 100 years old (Statistics Canada, 1999). The increasing proportion of older adults in the population also changes the dependency ratios; this increase in the numbers of older adults, who depend on decreasing numbers of young and middle aged persons, is causing concern among younger people about rising costs that will likely occur when the generation previous to themselves becomes old (Novak, 1997).

Most elderly persons are women and the prevalence increases with age;

in the late nineties, more than seventy percent of people over eighty five years old were women (Statistics Canada, 1999). Family caregivers of the elderly in the community are also primarily women — the spouses, daughters, daughters-in-law, nieces and grand-daughters of the infirm. Among spouses in 1997, for example, more than thirty-one percent of males cared for spouses who were ill, while more than sixty-eight percent of women cared for spouses who were ill. Daughters provided care for more than sixty-three percent of the parents who received care, while sons provided care for fifty-four percent of parents receiving care (Statistics Canada, 1997b). Individuals providing care in institutions have also been primarily women.

In 1996, older persons were more apt than younger persons to live in special care homes, including municipal homes for the aged, charitable homes for the aged, non-profit nursing homes and for-profit nursing homes. More than seven percent of all Canadian seniors and more than thirty-four percent of those over 85 years lived in institutions. Three quarters of all residents of institutions were seniors. Older males were less likely to live in health care institutions than older women (Statistics Canada, 1999). In 1991, among Canadians with disabilities over 85 years, sixty-two percent of women and only forty-six percent of men lived in institutions. Among these seniors, more than ninety percent had a chronic health problem and more than sixty percent had trouble remembering things; but forty three percent of institutionalized older adults said their health was good, very good or excellent. (Statistics Canada,

1997a).

In the early nineties, the work environment in long-term care settings varied across the private and public spectrum: some homes had as few as four beds while others housed more than two hundred elders. In residential care facilities in Canada in 1992/93 more than 37,000 beds were provided by the private, for-profit sector, over 5,000 beds were provided by religious organizations, almost 8,000 were not-for-profit charitable organizations and in excess of 17,500 were municipally funded (Statistics Canada, 1994a). Many workers in these institutions were considered part-time although they may have worked almost full-time hours. In 1993, among more than 110,000 workers in these care settings, about equal numbers of employees worked full time as part time (Statistics Canada, 1994a). In 1994, the daily cost per resident was $94 per day (Statistics Canada, 1997a) with dollars provided from multiple sources: health insurance, social assistance, provincial and municipal governments, other agencies, self payment and others (Statistics Canada, 1996a).

The workers in long-term care, for the most part health-care aides, registered practical nurses and registered nurses, work in a climate of disadvantage. In Canada in 1993, seventy-one percent of employed women worked in teaching, health, clerical, sales and service occupations, and had less tenure and lower wages than employed men (Statistics Canada, 1993). In 1994, within health, eighty-six percent of nurses but only twenty-six percent of physicians were women; and physicians earned double the salary of nurses

(Statistics Canada, 1994b). Overall, women earned forty nine percent of what men earned who worked in health care (Statistics Canada, 1993).

Among 24,371 registered nurses employed in nursing homes in Canada in 1995, approximately 2,000 functioned as head nurses, and more than 16,500 were in staff nurse positions (Statistics Canada, 1996b). Among female registered nurses overall in 1987, seventy-four percent were direct care nurses; among the fewer male nurses, sixty-five percent were direct care nurses. Seven percent of the females were head nurses, five percent were supervisors and two percent were directors or assistant directors. Among male registered nurses, fifteen percent were head nurses, seven percent were supervisors and four percent were directors or assistant directors (Statistics Canada, 1987). In 1990, nurses earned $30,230 if they were female and $32, 411 if they were male (Statistics Canada, 1994b).

A survey of more than three thousand members of the Ontario Association of Social Workers found that more than twenty-three hundred were female and fifty-six percent were over 50 years of age. The organization's members are a fraction of university trained social workers in the province; and social service workers are not represented by that association. Of the particular workers who were members, sixty-four identified themselves as working primarily with older adults; among these sixty-four workers, sixty were women and most were over 50 years of age (Ontario Association of Social Workers, 1999b). It is unknown how many other persons with social work training work

in long term care settings. Similar information was not available in regard to health-care aides and Registered Practical Nurses. Nevertheless, women are a clear majority of both those who receive and dispense care in the institutions that are part of the structure of our ageist society; questions about disadvantage, organizational power and powerlessness inevitably emerge.

Decision Making

Why decision making?

Decision making is central in the lives of older adults and is particularly related to autonomy, institutionalization, advance directives, competency, informed consent and also in the myriad of small but meaningful decisions made in everyone's daily life. While recipients of long-term care make few decisions themselves, their care is controlled and delivered through decisions made by others: client families, workers, managers and outside payers. Decisions impacting the lives of older adults extend from the older adults' bestowing on another their power of attorney, through to the delegation of life and death decisions that comprise the advance directives given to medical providers. Just as important, however, in one's day to day existence are those basic decisions about when one rises in the morning and what one eats on a particular day. These decisions are important to both those who are impaired and those who are not. Shawler et al (2001) concluded long-term care decision processes play a role in contributing to the loss of resident autonomy even among those capable of making decisions.

This drama of life decisions is played out by elders and their families, and by multi-disciplinary long-term care teams comprised mostly of nurses and augmented by other professionals; the drama transpires under the overall supervision of charge nurses and medical doctors, directors of care, administrators and ultimately the Minister of Health. Together, the decisions of these agents are the building blocks on which care outcomes, individual relationships and costs are based. The mere existence of the Advocacy Centre for the Elderly, Substitute Decisions Act (Government of Ontario, 1999) and long-term care facility compliance advisors are immediate clues to the centrality of decision processes in these settings.

Autonomy.

Autonomy is a common keyword in psychological journals particularly in relation to older persons. In particular, client autonomy has often been linked to well-being, mortality and the medical model while staff autonomy has been linked to race, education and employee type (Walton, 1985; Dunkle & Wykle, 1988; Arcus, 1999; Raynes, 1998; Kasser & Ryan, 1999; Williams et al 1996; Foner, 1995; Ackerman, 1997). Client decision making, or the lack of it, determined the resident's ability to influence the care they received, and in some cases may have also interfered with care provision itself (Reinardy, 1999). Proot et al (2000) identified routines of care, boredom, privacy concerns and other environmental issues as particular aspects of nursing home life that restrained autonomy. Residents in long-term care facilities preferred to be

involved in decisions related to major health concerns and also to such seemingly small parts of life as planning meals (Forbes & Hoffart, 1998).

Other studies related health and long-term care to the levels of autonomy, or decision making, by those providing care. A particularly relevant example came from Foner's study where she reported that nursing home rules "essential to guarantee the smooth functioning of the home, and patient well being, at the same time can interfere with aides' ability to provide compassionate and humane care" (1995, p. 235). She pointed out the complexity of health-care control that was visible in documentation and risk management standards set by the long-term care bureaucracy. She explained how this problem escalated further where the home was particularly successful; as such homes followed regulations intended to assure good care, the adherence to these rules also prevented good care.

Institutionalization.

There were two primary foci of most of the literature on long-term care decision making: literature focused on decisions to institutionalize and literature that described the establishment of advance directives. This dissertation deals with issues of institutionalization, but not with advance directives. Loss of decision autonomy was seen to accompany both the process of institutionalization and also simply one's status as care recipient (Collopy, 1988; High & Rowles, 1995). The resident's adjustment to life in a nursing home was influenced by their sense of self efficacy and less so by their locus of control

(Johnson, Stone, Altmaier & Berdahl, 1998). In regard to both advance directives and the decision to move into an institution, client involvement was minimal regardless of the fact that their cooperation would become a fundamental part of the decision outcome (Noonan, Tennstedt & Rebelsky,1999; McAuley & Travis, 1997; Reinardy & Kane, 1999; Degner & Beaton,1987; Bradley, Peiris & Wetle, 1998; Reinardy, 1995; Groger,1994). As frailty increased, proxy decision makers assumed more and more decisions and client choice was "minaturized"; and those small decisions assumed more importance in the eyes of the resident (Rubinstein, Kilbride & Nagy, 1992; Everard, Rowles & High, 1994). Few researchers focused on the care recipient's actual ability to make the decisions that would influence care outcomes, morale and life satisfaction (Reinardy, 1992).

Competency, informed consent and ethical decision-making.

Questions of competency and informed consent have been extensively discussed by ethicists and researchers. When clients lack capacity, decisions by substitute decision makers are accepted in law (Franzi, Orgren & Rozance, 1994). But although proxy decision makers must by law have a role, the views of residents should not be ignored. Several authors have linked decision making to autonomy and then to ethics, particularly in writing about residents in long-term care facilities. In Haddad's (1994) work in the area of ethics and the decision making of the front line worker, she defined a five step process whereby workers can attempt to make an ethical decision. She identified the

need for processes that would reach workers at all levels in the organization and the need for research that encourages workers to do what they know is right, even though she acknowledges they have the "least authority" and a "great deal of responsibility" (Haddad, 1994, p.77) in the organization.

Decision-Making Power in Long-Term Care Facilities

Older adults receive care in institutional and non-institutional settings. However, persons who received care in community settings were found generally to function at higher physical and cognitive levels, to be less externally oriented and to achieve greater levels of self actualization than similar people in institutions (Sijuwade, 1996; Trydegard, 1998). In institutions, issues of organizational policy (care coverage, entry and exit circumstances, the costs of care planning and the scheduling of routines) have been found to influence autonomy levels (Capitman & Sciegaj, 1995). Kane argued safety and routine have become more important than quality of life, and she suggested residents are treated as staff are treated (Kane, 2001). In home health care, the use of strategies to incorporate client uniqueness and strength into the work "may be inhibited by the medical model governing most treatment decisions" (Pray, 1992, p. 71). Not only was the type of residence where older women lived related to autonomy and health, but the type of control that arose from the type of residence was also linked to their use of problem solving skills (Collins, Luszcz, Lawson & Keeves, 1997). Some authors have raised ethical concerns because of the reduced autonomy and lack of opportunity to maximize strengths

found among older people in institutional settings (Collopy, Dubler & Zucherman, 1990; Pray, 1992).

Collopy identified six polarities of long-term care autonomy and specified decision making within those polarities: decisional versus executional, direct versus delegated, competent versus incapacitated, authentic versus inauthentic, immediate versus long range and negative versus positive. He also developed links between the suppression of autonomy and the receipt of care (Collopy, 1988). A related study asked staff in a nursing home to rate the level of autonomous resident function in case vignettes that reflected Collopy's definitions; this study found staff background variables such as race, and education level most influenced staff perceptions of the resident level of autonomy (Mullins, Moody, Mattiasson, & Andersson, 1998).

Decision-making action and inaction in long-term care facilities is unique because of the preponderance of proxy decision makers. Resident decision data reflected by family or staff, may not be a reliable indicator of actual resident preferences. For example, where proxy decision makers make decisions that impact daily living and even life and death, direct resident input could be a valuable addition, regardless of the challenges posed by frailty and cognitive impairment. Fienberg and Whitlatch recently published the results of their study of choice consistency among moderately cognitively impaired individuals; they found even those persons with mild to moderate impairment responded accurately about their own demographic information and were able

"to respond consistently to questions about preferences, choices, and their own involvement in decisions about daily living" (Fienberg & Whitlatch, 2001, p.380). Residents and nursing assistants agreed, in another study, about the importance of control and choice by residents living in long-term care settings; however, residents identified out trips and telephone use as most important whereas nursing assistants identified activities such as bingo and arts and crafts as most important (Kane, R,; Freeman, Iris; Caplan, Arthur; Aroskar, Mila & Urv-Wong, E. Kristi, 1990).

Decision making varies from one staff level to another as well. In 101 nursing homes, Connor (1992) found the ways workers in various positions participated differently in decisions related to the size of the organization and the skill level of their position. Decision making varied more at lower levels than among administrators, nursing directors and owners. These data were compromised somewhat in terms of my study because they were gathered only from home administrators. The participation in decision making by registered nurses varies but their influence has been described as primarily limited to raising an issue initially and attending the informal meetings where decisions were discussed (Anderson & McDaniel, 1998). Staff decision-making patterns, similar across teams dominated by nurses, determine the work environment but Cott found nurses carry out decisions made by others, for the most part (Cott, 1995). Lauri et al identified analytical and intuitive cognitive decision processes used by nurses, finding most "analytically oriented decision makers were found

in long-term care; analytical decision processes include developing care plans, gathering information and defining issues but excludes intuitive processes including of administering and assessment of care" (Lauri, Salanterae, Chalmers et al, 2001. p. 83). In an earlier study by these authors, nursing decisions were more associated with a specific task and type of care than with the level of knowledge and experience (Lauri & Salanterae, 1998). Administrators had the most influence in these organizations (Smith, Discenza & Saxberg, 1978).

Decision limitations extend to other staff as well. Interview and questionnaire data from 233 supervisory and non-supervisory staff at nursing homes identified overall limited staff involvement in the decision-making process (Smith, Discenza & Saxberg, 1978, p. 159). In the case of physicians, decision making with community based elders was "influenced by professional values, institutional constraints and cultural forms" (Kaufman, 1995, p. 481). The perceived decision-making capacity of facility staff, however, related to "structural characteristics including ownership type, number of beds in the facility, and the number of facilities owned by the parent corporation" (Kruzich, 1995, p. 207). Feelings of powerlessness in women care givers have been associated with lack of control, value conflicts and too few resources; powerfulness, on the other hand, was felt where the woman's opinions were valued, when she thought she could make change happen and where she had time for her own needs (Rutman, 1996). Tulloch (1990), a resident of a long-term care facility herself, pointed out "caregivers must be highly skilled

and feel very secure within themselves to gracefully accept residents' refusal of certain measures of care" (p. 83). Kruzich (1995) identified the shortage of empirical research about perceptions of control by nursing home residents and staff. Nevertheless, when Kruzich and Clinton (1989) considered staff alone in an earlier study, they found "The means indicate that individuals at higher positions in the hierarchy perceive a greater level of influence in decision making". (p.47)

Kruzich (1995) identified two areas of staff decision making (about resident care and about staff) and two types of organizational characteristics — structural (ownership type, unionization, etc.) and process (unit rotation, etc). She concluded her measure was "reliable and appropriate for use in assessing perceived decision-making influence of various staff positions in diverse nursing home settings" (214). Moreover, she pointed to the need for research that would connect organizational variables to resident outcomes. Her instrument, Staff Involvement in Decision Making scale, (National Institute on Aging Research Instruments, 1989) along with other measures, was used to determine decision-making influence held by staff in relationship to resident satisfaction in long-term care (Kruzich & Powell, 1995). In her study, the influence of social workers related to numbers of social work staff and to administrator autonomy. Where social work influence was strong, routines were less rigid and resident satisfaction was increased. Autonomous decisions at various levels, then, related to organizational size, funding base, hours worked, worker position, job

satisfaction and turnover (Connor, 1992; Gleason–Wynn & Mindel 1999; Singh & Schwab, 1998; Kruzich, 1995). This particular instrument, the *Staff Involvement in Decision Making* scale, has been adapted for use in this study.

III: Theoretical Framework

This study is about decision-making, but about decision-making as a prime indicator and instrument of organizational power. The theoretical frame for the study has two major elements: organizational power theory including Weber's (1947) theory of the bureaucracy and Prigogine and Stengers' (1984) theory of chaos. In the discussion portion of the dissertation, I argue that, while the home studied is an embodiment of Weber's bureaucracy, when the system is studied under the light of chaos theory, new visions become possible. And those new visions are of organizational power constrained. This part of the literature review addresses all three of these elements.

Connections between Decision-Making and Power

Because this study integrates long-term care decision making with the underlying dynamics of individual and organizational power, some primary sources regarding those dynamics were reviewed, particularly as they related to differential power. For example, while the human relations school of thinking asserts man is basically good, enjoys work and is committed to the organizations in his world, classical management theory maintains people dislike work and need direction and coercion if organizational goals are to be achieved. A human relations approach to organizations includes decision making by consensus and democratic leadership whereas classical management theory asserts a top down style of management (Hasenfeld, 1983). Organizational priorities prevail and power, though perhaps unspoken, exists. Matters of gender, age and resource

allocation are based in differential power relations in long-term care. Genevay made a direct link between the decisions made by staff, who themselves have little power, and the client's dependency, stating "indeed, letting go of control brings better results, but it is very very hard to do" (Genevay, 1994, p. 14), particularly where workers have little power in their own lives. Chronicity and caring associate with dependence and powerlessness, whereas acuteness and science are connected to power and legitimacy. A curious dichotomy of dignity and abuse, both with their public and private expressions and experiences, may co-exist (Arnason, 1998).

Levels of Decision-Making Power in Organizations

Theorists have postulated varying perspectives related to levels of decisions in organizations. What follows is a summary of those views. Several writers identified mechanisms used by organizations that develop and reinforce unequal power dynamics; the mechanisms include hierarchy, ownership, communication, science and technology, roles, a tendency to homogeneity, and traditional management (Hugman, 1991; Ragins & Sundstrom, 1989; Kanter, 1977). Such organizations deal with those who do not fit and those who threaten the status quo by segregating or controlling them (Ferguson, 1984). Communication patterns of those in charge, and the failure to discuss structures of power that marginalize groups of people, protect organizations from demands by less powerful groups (Mills & Simmons, 1999, p.178). When discussion centres on health technologies and disease labels, disputes about marginalization

can be avoided.

The bureaucracy wields power and control over the most disadvantaged through its structure and policy; employees may not even be aware of their role in supporting its power. Control of uncertainty is assured while those in charge gain a power-over others that invades privacy, and demands compliance (Daft, 1998; Mills & Simmons, 1999). Human service organizations, however, are difficult to evaluate and control since work occurs within, and output originates from, interpersonal interaction. The kind of work task also influences the power; agencies that maintain people who seem to be functioning well are judged differently from those that control persons who seem to be functioning poorly (Hasenfeld, 1983).

Political economists see power emerging from the centrality of the work unit's role in a competition between internal and external forces to express organization values (Hasenfeld, 1983). Human service organizations demonstrate an interesting inconsistency in values, as they symbolize both a caring society and also a mechanism of social control by government (Hasenfeld, 1992). Other theorists examine the influence of the environment or of multiple contingencies that call for differentiation (Hasenfeld, 1983). Astley and Sachdeva pull diverse perspectives together ultimately calling for an analysis of multiple interlocking systems of power (Astley & Sachdeva, 1984). Differential relations of power are described by traditional theorists as constructed on individual and also organizational foundations.

Relations of power between two parties are perpetuated by the acceptance of the hierarchical authority by the person without power (Hasenfeld, 1983). The senior manager has considerable discretion as a tool of social control (Mills & Simmons, 1999); however, managers are also controlled by others through "strategies of surveillance" (Gutting, 1994; Reed, 1996). Lower level managers, on the other hand, are supervised more directly and have little discretion (Ferguson, 1984). Bureaucrats then justify this system of control by arguing for rationality (Kanter, 1977; Mills & Simmons, 1999).

A drive toward homogeneity comes from the enjoyment people experience when surrounded by like-minded people, from similar backgrounds; one can feel acceptable. The person's understanding of the world is validated and a sense of we-ness and trust develops; uncertainty is a lesser issue, and disadvantage of those who do not fit is reinforced. The hiring of homogeneous peers avoids the discomfort that might accompany the hiring of a deviant into management ranks, for example (Kanter, 1977). When pressured to work in a diverse workplace, people are forced to try to understand the perspectives of co-workers (Sherer, 1998). It is simpler for those in power to choose to build a homogeneous organization.

A different people-focused management, recommended by some, does not fit with the styles just discussed or with the dominant management style of bureaucracies (Jacques, 1998). Foucault (Gutting, 1994) identified a shift in concentration by power brokers that moves the focus away from themselves

toward their target, making the power almost invisible and more formidable than power that can be seen (Hugman, 1991; Schneider, 1996). For example, as long-term care providers focus on client need, their own power is less visible. And long-term care decisions are made in a context of bureaucracy and finely tuned management structures.

Levels of Decision-Making Power Specific to Bureaucratic Organizations

Organizational power has been discussed since Moses delegated authority over Israel along hierarchical lines: "and Moses chose able men out of all Israel, and made them heads over the people, rulers of thousands, rulers of hundreds, rulers of fifties and rulers of tens." (Exodus, Chapter 18, p. 64). Socrates, too, described the able president and the similarities of public and private institutions (Shafritz & Ott, 1992). In *The Prince*, written originally in 1513, Machiavelli used the metaphor of a prince to demonstrate control-seeking, previously hidden, powers in organizations (Machiavelli,1513, 1977). In today's bureaucratic organizations power may be visible or invisible, active or inactive; it is difficult to define as a single entity. For example, in Weber's principles of bureaucracy he described the organizational structures from which power emanates.

> The organization of offices follows the principle of hierarchy; that is, each lower office is under the control and supervision of a higher one. There is a right of appeal and of statement of

> grievances from the lower to the higher.... The rules which regulate the conduct of an office may be technical rules or norms. In both cases, if their application is to be fully rational, specialized training is necessary....In the rational type it is a matter of principle that the members of the administrative staff should be completely separated from the ownership of the means of production....Administrative acts, decisions, and rules are formulated and recorded in writing, even in cases where oral discussion is the rule or is even mandatory. (Weber, 1947, p. 331)

Power is one individual's capacity to impose his or her will on others; the bureaucracy describes the circumstances under which one obeys another through its claims of knowledge, efficiency and its rational control over people (Weber, 1947). This kind of rational bureaucracy becomes more complex when an interchange of resources results in more than one power centre within one organizational entity.

A belief that bureaucracy acts as a meritocracy, rewarding only expertise and technical competence, does not consider many complex biases and disadvantages (Mintzberg, 1983, Mills & Simmons, 1999) where differential power comes from a myriad of interpersonal and bureaucratic processes and structures. In the end, those who lack system and position power, political

influence, resources, and powerful alliances cannot create power (Clegg, 1989; Kanter, 1977). The models of service and decision making that occur in organizations and originate from this kind of differential power base do not always consider the impact on helping when policies change, even in organizations that exist for the purpose of helping (Hasenfeld, 1983). The bottom line focus of the meritocracy can result in a machine-like efficiency in a bureaucracy that comes, in part, from a division of labour where workers and owners work separately so many workers can function under the control of one bureaucratic official (Hasenfeld, 1983; Weber, 1947). This control garners organizational knowledge to the bureaucrat along with an ordered, mechanical and unemotional power; the one in control can now "confer grace" on others indiscriminately (Weber, 1947, p. 342).

The hierarchy of the bureaucracy constructs and marks power through job descriptions, credentialing and titles (Hugman, 1991). Accountability, laid on by this hierarchy, is embedded in organizational language; professional jargon maintains power for those who understand and creates a distance from those who do not. As workers translate client reality into reports, the person's life becomes part of the bureaucracy and the place of the worker in the professional world is assured (De Montigny, 1995). This rationality and routinization of authority is reinforced when organizations seem unpredictable to those who are marginalized (Ferguson, 1984). As workers enforce management directives, the supervisor's role and power is enhanced while the worker's

position becomes dependent on the position of the superior (Weber, 1947). Further divisions of work protect the supervisor's exclusive, and now the only complete, knowledge of the organization, increasing their power as a result (Kanter, 1977).

When we look beyond the rhetoric, power relations between contending interest groups and underlying power structures are revealed. Multiple sources of power and conflicting lines of authority create a decision-making process that is powerful and complex (Hasenfeld, 1983). Planners select service technologies based on the preferences of the powerful and the competition of values and economics, rather than the needs of the client, creating funding, environmental and interpersonal barriers (Gutierrez, GlenMaye, & DeLois, 1995), and disadvantage for both clients and workers (Ferguson, 1984; Kanter, 1977; Shera & Page, 1995). These complex and conflicting sources of power and inequality, together with issues of race, gender and class, are in some ways the very essence of bureaucracy (Mills & Simmons, 1999), damaging workers and clients alike. Differential relations of power become almost "synonymous with the activities themselves"(Ferguson, 1984, p. 88).

Players in these influential bureaucracies try to maximize their own resources and minimize costs through an interdependent exchange which is ultimately governed by the power of each player (Hasenfeld, 1992). The exchange strengthens the power of some, influences the organization itself and determines resources. Each party needs the other, although elderly clients are

more dependent on the organization than the organization is on the client; the client's lack of options underscores their disadvantage. People with power use discretion to help others bypass rules or get resources; connections to powerful people builds power (Kanter, 1977). In a similar way, powerful agencies bolster their own positions. This exchange of resources can lead to resource concentration, centralized power and routinization of skills while organizations protect the bottom line. Workers become replaceable and organizations have more power (Hasenfeld, 1992; 1983). Sarri and Hasenfeld suggested this exchange and the centrality of the client/worker relationship could be the base of an investigation that looks simultaneously at both sides of the exchange - the organization and the client (1978).

Organizational decisions are shaped as resources are distributed to the most central individuals and units (Hasenfeld, 1983). For example, where an individual, unit or agency controls the access to scientific or technological information, their power is enhanced (Gruber & Trickett, 1987). Those in charge control not only resources, but clients, and when workers support decisions made by others, their compliance is assured. In this exchange, some clients are seen as more deserving than others; and, when professionals represent client rights, they advantage some but disadvantage others (Hasenfeld,1992; 1983).

Even human service organizations that serve vulnerable low income clients may focus more on social control and surveillance than on providing

help; this limits client self-determination and strengthens compliance. "The asymmetrical power relationship between the agency and the client, and hence between the worker and the client, is maintained throughout the structure of social services" (Hasenfeld,1992, p. 281-282). Worker advantage is enhanced by expertise, their ability to limit client access and also to link service availability to client compliance. This link can create an "inequality of practice and practice of inequality" (Hasenfeld,1992, p. 282). In long-term care, such unequal practice is laced with the privilege given to white middle class values (self control and individualism) by biomedical science and by the priority of cost control over service delivery to vulnerable people (Miewald, 1997; Sarri & Hasenfeld, 1978, Stein, 2001).

Politics, or the use of power to influence decisions, reinforces the priorities of the elite (Daft, 1998; Kanter, 1977; Hasenfeld, 1983) giving privileged persons control of budgets and clients, and service access (Weber, 1947). For example, control by medical personnel of patient selection gives high end hospitals superior positions that are fortified when less desirable patients are referred to other institutions, like long-term care facilities. This inequality is seen as legitimate; staff comply, and the unfairness is not challenged by those with the countervailing power, such as physicians or government policy makers (Hasenfeld, 1983). When hospitals refer older people to nursing homes, the power of the hospital is reinforced and the power of the elder and the nursing home is diminished. The pyramidal structures created with the control of work

in the industrial age factories (Ferguson, 1984), remain today. Though organizations seem to be striving to meet their stated goals, the supervisor or bureaucrat sets the rules, workers feel repressed and creativity is quashed (Ferguson, 1984, p. 90).

Units of workers bifurcate as authority is delegated to some and not to others. When organizational rules are imposed, workers can become defensive and respond like the clients who subsequently interface with them; they may become as rigidly rule focused as the organization itself (Hasenfeld, 1983). Teamwork between units or people, although a valuable strategy, can only occur with equality and trust among members; the differential authority just described prevents equality (Peters, 1987; Ross & LaCroix, 1996; Seymour, 1997). Adherence to the rules protecting the organization becomes the overarching goal of the bureaucrat. Actions that justify and maintain the bureaucracy, while claiming an efficiency goal, assure self perpetuation. When we add the organization's rationality to this interpersonal exchange, the result is stunning. The organization creates the appearance of accountability, rationality and neutrality while simultaneously disadvantaging its people and protecting itself (Ferguson, 1984).

Levels of Decision-Making Power in Long-Term Care Organizations

Levels of power in long-term care organizations, while impacted by factors similar to those already defined, are compounded by increased numbers of older adults, society's focus on productivity and by our ability to extend life

with advanced technology. Those with resources or physical health knowledge decide who receives what treatment in a health system where there is not enough money for everything (Dimond & Markowitz, 1995; Goold, 1996; Sossin, 1994). The dominance of the doctor in health care, for example, is accentuated by class and gender differences among the professions and by the exclusivity of medical and scientific knowledge; real teamwork is unlikely in such a setting (Hasenfeld, 1983). The momentum is toward more cost efficiencies, increased power differentials and less, not more, patient focus in these organizations. Specific "institutional constraints" (Lidz & Arnold, 1990, p.65) impacting on resident autonomy include what Lidz and Arnold call "entry rituals...dedifferentiation" (p.66) of living accommodation, dedifferentiation of authority, the need to ask for permission, activities scheduled by others, the maintenance of negative stereotypes of staff and resident by the other, lack of privacy and the existence of the "rational plan" (p.67).

Work develops in response to the environment and the beliefs of decision makers; the completion of work justifies not only the work then, but also the beliefs of the powerful. For example, clients are grouped, labelled and recast according to precise criteria (Hasenfeld, 1983); in long-term care, clients are separated according to their cognitive function. In such segregated environments, a focus on efficiency causes heightened worker awareness of resident similarities rather than differences; if they attended to difference, their work would be more complex and expensive. Professionals are also more apt to

label healthy people as sick or deviant than the reverse because there are fewer negative consequences for those professionals (Hasenfeld, 1983). An incorrect diagnosis that labels an elder as competent would elicit a more negative societal reaction than would an incorrect diagnosis of dementia. When providers over-diagnose and over-treat these labelled individuals, they justify their own professional status and prevent empty beds (Ferguson, 1984).

The consequences of client dependency are parallel in many respects to those for workers, although worker dependency is obscured by the salary reward (Ferguson, 1984). Work with chronic care patients, with lower social status or less cognitive ability, is often assigned to para-professionals and avoided by higher status professionals whose practice ideologies are oriented towards verbal, intelligent, motivated patients. As professionals with prestige delegate this "dirty work" (De Montigne, 1995, p. 217) to other workers, those lower level workers serve as a buffer between clients and the more prestigious professionals. The stratification of staff power is replicated and maintained, then, by the stratification of their work according to its type and its desirability (Hasenfeld,1983; Hugman,1991).

In long-term care organizations, the quality of care declines when or if informed consent and cooperation is compromised for cost containment or to maintain power. Truly informed consent is based in trust, cooperation and genuine consensus. However, it is too often only a legal, bureaucratic hurdle without trust, cooperation or real communication (Hasenfeld,1992). Real

informed consent would increase the power of older adults; they would move "from a dependent person to an equal moral agent."(p.291). The complexity of these questions of informed consent are magnified by reduced competency or capacity (Davitt & Kaye, 1996). The very existence of competency assessors, Ontario's relatively new Substitute Decisions Act of 1992 (Government of Ontario, 1999) and the Ontario Office of the Public Guardian and Trustee demonstrates the power of the state, and society's attention to these relationships of dependence, power and consent (Iris, 1990).

Levels of Decision-Making Power in Individuals

While decision-making power differentials have been defined organizationally, each individual plays a vital role in power relations. Lukes (1974) succinctly defined power as occurring when "A exercises power over B when A affects B in a manner contrary to B's interests" (p. 27). His three fundamental dimensions of power have been often quoted by power theorists. In the first dimension of power he focuses on obvious power seen in behaviour, decision making, key issues of disagreement, observable overt conflict and subjective interests. In his second dimension, he adds less obvious components to the first: non decision making, difference over potential issues and covert conflict. His most complex and hidden third dimension adds control over a political agenda though not necessarily by decisions, and latent conflict to those previously identified.

In their classic typology, French and Raven (1959) described the bases of

social power as reward, coercion, expertise, legitimacy and referential. Reward power exists when one believes the other is capable of providing a reward; coercive power is found where one believes the other can punish if one does not comply; legitimate power comes through the belief and internalized values held by the one that the other has the right to influence; referent power exists where one has a feeling of oneness with the other; and finally expert power is based in knowledge one attributes to the other in a given area. The description of the bases of power of these often quoted authors provides a beginning place for this review of the foundations of power in long-term care organizations.

While a powerful person avoids a decision, ignores a request, or uses a meeting to delay or prevent unwanted decisions, those with less power are unable to create similar circumstances for themselves (Clegg, 1989). Such interpersonal choices by the powerful decide whose preferences are honoured, establish communication patterns and select models of decision making; their choices determine which individuals have how much autonomy and discretion (Hasenfeld, 1983). Organizational mandate, culture, language and structure are shaped by these interpersonal relationships. Peters (1987) claims management personnel can also influence the relationship development positively by empowering workers; yet in so doing, they also exercise and maintain their own power.

Personal power exhibits itself in one's ability to act independently, control another's action, bestow power, or shape another's consciousness in a

way that resembles consensus (Hugman, 1991; Ragins & Sundstrom, 1989). Resources, such as votes, jobs or money can enhance one's capacity to convince another to act or not act, the capacity to exclude the other, or the capacity to manipulate a non-consensus so it masquerades as consensus. The construction of language and management of information convinces those who have less power they will escape feelings of powerlessness by accepting the values of others; they often comply using language that gives authority to the other (Hasenfeld, 1983). Organizational goals express the priorities of payers with power, even though these may be incompatible with client needs (Hasenfeld, 1992). In relationships between people, and between people and institutions, power assures that the outcomes are those favoured by the powerful. (Harlos, 1995; Daft, 1998).

Social class, economic status, race, language and gender influence both clients and organizations; people are processed differently depending on these characteristics. Among these, the visibility of gender and race gives these two characteristics prominence (Fagenson, 1993; Wilson, 1997). A bias toward assimilation and homogeneity in organizations calls for difference and diversity to be ignored; discussions of equality or diversity could challenge the status quo (Mills & Simmons, 1999). The base of individual power is also in the individual's activities, alliances, and access to resources, information and knowledge (Clegg, 1989; Harlos, 1995; Kanter, 1977; Ragins & Sundstrom, 1989). Power seems to be defined and related inversely to one's dependency on another, creating the relationship of power-over and subservience (Harlos,

1995).

Gender advantage arises not only from physical difference, but also from care giving demands, the language bias of aging and care giving (McGowan, Morouney & Bradshaw, 2000; Aronson, 1994), the history of gender based work and societal roles; these are the differences that slow women's advancement (Fagenson, 1993; Hugman, 1991; West & Fenstermaker, 1995). While criticisms lobbed at female supervisors as controlling and shrill may not be valid, there are differences in work styles; men are competitive and seek power whereas women communicate and seek consensus (Kanter, 1977). Women manage at the middle and bottom of the hierarchy and are paid less (Fagenson, 1993; Ragins & Sundstrom, 1989). When disadvantage leads female managers to passivity, this resembles the reaction of older service recipients when interfacing with health-care power (Ragins & Sundstrom, 1989; West & Fenstermaker, 1995).

Language oppresses if we treat persons as 'other'; naming the disadvantaged transforms them, whereas, the privileged use the same language to resist transformation (Marcoccio, 1995). Cohen points out when we define elders as at risk, frail or impaired, we disadvantage them with our language use (Cohen, E., 1990). Male-based organizational language (rivals, end-run, battles) excludes those who do not identify with these words (Harlos, 1995; Machiavelli, 1513, 1977). Information and its control is also associated with power particularly in a world of increased complexity. When information flows

in only one direction, such as from client to worker but not the reverse, the one who gives but does not receive information is disadvantaged. Bureaucracy itself controls information and directs its visibility (Ferguson, 1984).

People at lower levels influence decisions and increase power through their personality, knowledge, position, access to information and their compatibility with power (Daft, 1998; Ragins & Sundstrom, 1989). In Janeway's (1975) classic essay, she points out the "powerful are also afraid of the weak" (p. 105). Through their compliance, the weak grant power to the strong. Conversely, managers with little power may become rigid and authoritarian (Kanter, 1977). Male and female clients, workers and middle managers with little power survive by taking on "strategies of femininity" (Ferguson, 1984, p. 145), reinforcing and legitimizing the status quo. Already at the bottom of the hierarchy in a health context that values knowledge, information and science, the elder with diminished cognitive ability has little influence (Healy, 1998).

Power, influence and authority permeate the workplace. Managers seeking prominence are expected to devote their lives to their career. Secretaries find informal power through the status of the boss, in their access to his or her hidden information (Kanter, 1977). Clients must adopt an image acceptable to the organization; when they are old and female, the movement is toward passivity and compliance. Differential power relations influence people at all levels — managers, direct care workers and recipients of care — and there are

several parallels between personnel levels in long-term care facilities — that is, management, direct care providers and recipients of care.

Individual decision-making power at management level.

Management power originates in knowledge and information, in professional titles and discourse, and in the connection of individuals with scientific or technical knowledge or with the state's formalized bureaucracy (Clegg, 1989). As one is able to control health information, organizational norms and regulations or professional codes, one retains associated power, salary levels and lifestyle (De Montigny, 1995). Furthermore, discourse cannot be separated from the relations of authority that privilege some forms of knowledge; it is also the vehicle by which organizational and management theories have developed. As managers represent organizations in discourse with outsiders, they control the exchange and style of information and enhance organizational success (Ragins & Sundstrom, 1989; Peters, 1987; Singh & Schwab, 1998).

Formal authority in bureaucratic health-care organizations assures directives are acted on, and it determines who delegates to middle managers — the doctor or the president (Hasenfeld, 1983). A less formal discretional authority allows a specific person to designate who gets what service, often invisibly. As decisions are invisible, those making the decisions remain unchallenged, confirming their status (Hasenfeld,1992). More discretion results from this status and from professional knowledge, enhancing the professional's

decision-making capacity about who gets what treatment and how much work gets done (Regehr & Antle, 1997; Lipsky, 1980). Managers use mechanisms such as hiring processes, operating procedures, and supervision to control work behaviours, and meet goals. Authority and power levels rise and fall with the organization's need for resources, whether the resource is money, legitimation, clients, or manpower. This concentration of authority protects the organization from change agents and may threaten democratic processes as a result (Hasenfeld, 1983).

The prestige and authority of health-care managers and professionals comes from organizational design, the scientific nature of work, connection with important organizational matters and the discretion they can exercise (Daft, 1998; Ragins & Sundstrom, 1989). Similarly, clients who have knowledge about professions experience more power than those who do not know (Birenbaum-Carmeli & Carmeli, 1996). Lipsky (1980) claims discretion also arises from the difficulty of directly supervising workers he labels "street level bureaucrats" (p.15) or routinizing their work (Hasenfeld, 1983). Differentials of professional prestige are accentuated by gender differences. For example, the prevalence of women in professions common to long-term care (nursing and social work), diminishes their prestige, giving other professions more status in comparison (Ragins & Sundstrom, 1989).

Managers with little power may protect their domain (Kanter, 1977, p. 194) or create resistance by building barriers (Kanter, 1977). One who is a

visible minority group member in senior management is often disadvantaged and stressed as a result (Ragins & Sundstrom, 1989; Ferguson, 1984) and these stressed managers worsen the worker's situation, completing the cycle of disempowerment. Further, women are sometimes even praised when they do not excel and rewarded for mediocrity, thereby maintaining the status quo (Ragins & Sundstrom, 1989). These low level managers may use what they have to gain success – rules, control and coercion. When limited power is associated with copious accountability, managers may become cautious and rule minded, remarkably like the bureaucrat (Kanter, 1977).

The concept of power-over requires elaboration. While workers obey rules of organizations that demand efficiency (Hasenfeld, 1983), professionals may not obey those rules, citing arguments based in professional values (Kaufman, 1995). Yet, their cooperation is essential to productivity. When supervisors monitor their subordinates, they increase their own power. The match of the ideals of workers to those of their superiors reinforces the status quo and discriminates against new workers who aspire to innovation that does not fit; creativity is stifled as a result (Hasenfeld, 1983). The patterns of power distribution distinguish innovative organizations from those that are not (Kanter, 1983).

Even titled professionals come under the authority of others with different expertise; for example, physicians set schedules and fees according to bureaucratic standards and authority (Hasenfeld, 1983). However, while they

are not managers, these professionals retain exclusive control of a complex activity; medical care and its risks are controlled by physicians and the control is sanctioned by government (McAuley & Travis, 1997). Professionals may even use bureaucratic rules to justify or hide their advanced level of discretion; they control deviant behaviours and maintain dominant ideologies, often using their discretion to do so. These professionals in bureaucracies can cause conflict between professional standards and routinization, a conflict between two mechanisms of control — professional autonomy and bureaucratic authority (Hasenfeld, 1992; 1983).

The disadvantage of femaleness in organizations has led some to identify the dominant organizational model as male. The exclusion of women is validated when preoccupation with rationality and control reject the "more feminine principles or values of cooperation, connection and mutual victories" (Harlos, 1995, p. 16). In this male ideology, the semi-secret organizational jargon creates distance from, and control of, those who do not know (Ferguson, 1984). Power is accentuated while the needs and collective concerns of people are ignored (Harlos, 1995; Barrow, 1998). In a human service environment where caregivers and older adults, largely women, seek a legitimate place, this paradigm must be questioned (Gummer, 1998; Mills & Simmons, 1999).

Differentials of power and opportunity exist for women, persons of colour and working class people (Mills & Simmons, 1999). Traits accompanying advantage are the same as those that accompany maleness.

Leaders are portrayed as, and expected to be, men (Klenke, 1996). Those with power to decide, control discrimination through evaluation criteria, information control and political networks (Fagenson, 1993). Managers build personal comfort by developing a homogeneous environment of people like themselves (Kanter, 1977; Ragins & Sundstrom, 1989). As superiors condone subordinates, they affirm their own superiority and the subordinates' inferiority; compliance by subordinates then ratifies the implicit agreement (Hasenfeld, 1983; Ferguson, 1984).

A "feminization" of workers occurs when those with less power assume female role characteristics, become supportive, non-assertive and dependent, reinforcing their lower status. Their dependence causes them to adopt the image that seems favoured by superiors; similarly, the poor or vulnerable seek the image that will impress their workers (Ferguson, 1984). The oppressed have now become willing participants in their oppression as they mimic the dominant group (Mills & Simmons, 1999).

Because men are usually associated with power and feel successful with power, women who are powerful may feel at odds with this status (Harlos, 1995). Successful women in the bureaucracy, often atypical, have survived through a foreign system where the values are in conflict with those usually espoused by women (Ferguson, 1984; Ragins & Sundstrom, 1989). While women uphold values such as care giving, nurturing and cooperation, bureaucracies reward competition and devalue feminist values. When we look

at gender, we "reveal the mechanisms by which power is exercised and inequality is produced" (West & Fenstermaker, 1995).

Managers and other powerful people in organizations may remain anonymous, using power in back room strategies such as voice and email surveillance (Clegg, 1989; Gutting, 1994; Reed, 1996). For example, compliance advisors, hospital discharge planners and community care coordinators have a great deal of decision-making power in the long-term care system, yet see the older adult and their formal or informal caregiver infrequently. Care recipients are increasingly powerless.

Individual decision-making power at direct care service provider levels.

Decision making and power that occurs at the direct care worker level is influenced by formal and informal, personal and organizational factors: position, gender and race, compliance and professional power, alliances, role models and the client group served (Hugman, 1991; Kanter, 1977; Laurence, 1998; Sherer, 1998). Levels of perceived worker control have been associated with increased satisfaction, commitment and performance and also with decreased levels of physical and emotional distress, absenteeism and turnover (Spector, 1986). Power-over is experienced by workers as both the dominator and the dominated. Rigid rules do not create control, but rather alienated and ritualistically compliant workers and, in a parallel way, perhaps also clients. The client's real life experience is discounted in a dehumanizing capitalistic society and direct care workers play a part in the dehumanizing process (De

Montigny, 1995).

Typical gender roles place women in the role of nurturer with limited autonomy while men fill the role of provider, often holding the authoritative position within the home, or within the institution. Even when women do not feel mastery in their work, they may assume blame if things go wrong. Altruistic human services support personal sacrifice by female workers especially when they feel at one with clients; they are prone to exploitation during times of organizational stress; it also provides a built-in professional morality that justifies the exploitation (De Montigny, 1995; Hasenfeld,1992). In health care, male directors often lead teams of female workers of the same professional designation; males are the decision makers, directors and surgeons, and females in the same professions are caregivers, frontline workers, and members of specialty areas with less power (Hugman, 1991; Carniol, 1987). As services focus more on care than on cure, both client and worker status decreases (Hugman, 1991; Laurence, 1992).

The routinization of women's work lowers their sense of control further, shapes alienation and develops the sense of powerlessness — increasing the likelihood that workers will be of disadvantaged gender and racial groups (Ross & Wright, 1998). Adler (1993) found the position held, better explains gender differences in autonomy than the gender composition of specific occupations. For example, decreased autonomy is better explained by the fact that the workers in long-term care provide for the most basic human needs than

by the fact that most nurses are women. In female-dominated occupations, particularly the altruistic care of marginalized vulnerable old women, the dominant ideology assures women are direct care workers and men are managers (Hasenfeld, 1992; Hugman, 1991).

Trust in workers does not protect clients. Clients without power are expected to trust experts with authority, because of their privileged position; the trust does not necessarily flow the other way. If this were a power-dependence exchange, trust would be mutual. This relationship between dependence, power and trust is "the key to understanding the enigma of human service organizations" (Hasenfeld,1992, p. 21). If social workers wish to truly empower those at the bottom of the power-dependence exchange, we must clearly see our own privilege, discretion and power in the client's world and use our discretion to balance power. When supervisors request work plans, schedules or reports to restrict worker discretion, they also limit creativity (Hasenfeld, 1992; 1983).

Workers with the most client contact, semi-professionals, feel some sense of power when they can control working conditions; but they are closely supervised and help to shield professionals from direct client contact (Hasenfeld, 1983). Conversely, an employee with more experience than the supervisor in a particular field may also have more power than the supervisor. To improve their own position, workers may assign less desirable work and few rewards to lower level workers thereby increasing levels of alienation. But it is

precisely these potentially alienated lower level workers who have the greatest client contact. These lowest workers in the chain may be more interested in reducing their own undesirable work than in serving clients, raising questions about quality of care. Empowerment strategies will only be effective if they are developed on all levels – worker and client level, organizational level and policy level (Gutierrez et al., 1995; Hasenfeld, 1983; 1992). Where power is shared, and everyone's ideas are mined, organizations flourish (Kanter, 1983).

As workers who care–for clients, social workers are seen as less expert than those who control and care–about the physical care, such as physicians and to a lesser extent, nurses (Haug, 1996; Hugman, 1991; Muller, 1986). Connection to those who are sick or otherwise disadvantaged further disempowers those direct care workers, particularly when the work done is not seen by others as essential. Ultimately, social workers, nurses and other direct care workers may exhibit compliant, feminized behaviours (Hugman, 1991; Sarri & Hasenfeld, 1978).

As helpers, direct care workers "play to several audiences" (Donnelly, 1992) and have the access that ensures patient compliance with the wishes of the professionals in charge. Social workers, for example, "help shape people's perceptions" (Hardy & Leiba-O'Sullivan, 1998, p. 456) about the benefits of health care; and, by supporting the system of care these workers may also validate the health–care provider's definition of the subject, or patient (Clegg, 1989). Social workers and members of many other professions, managers,

secretaries, and even the wives of executives, take on roles assigned implicitly or explicitly by the organization, and with those roles, also complex formal and informal power differentials (Kanter, 1977).

While social workers, for example, may define who gets what service (Regehr & Antle, 1997) we might also question whether we can improve the level of power held by the client when worker/client relationships are themselves hierarchical (Cohen, 1998). We may avoid even discussing power and seek distance from it instead (Carniol, 1987). Interestingly, few differences have been found between the influence of director of social work and direct care social workers in nursing homes; however, ownership, number of social workers and the length of employment are related (Kruzich & Powell, 1995).

Empowered workers would perhaps enable people to control their environment and therefore, their lives. But, although organizational theorists may promote employee empowerment, it is often to meet organizational needs rather than those of employees (Peters, 1987; Thorlakson & Murray, 1996). This empowerment in service to the organizational agenda does not necessarily help the client. If the goal of employee empowerment were real, work conditions and service to consumers could be enhanced (Cherns, 1987; Moore & Kelly, 1996; Peters, 1987). True empowerment is often taken rather than given and results in a loosening of control that may be uncomfortable for workers or administrators (Hardy & Leiba-O'Sullivan, 1998). In the end, although work does satisfy the needs of some workers for social relationship, it

is more positive for the powerful than those without power; even in empowered environments, actions generate power. "Power begets power" (Kanter, p.168, 1977; Mills & Simmons, 1999).

Participation in decisions builds morale, and sends the message that one's views are valued; and when workers control their own work they function better and remain longer (Hasenfeld,1992; Jinnett & Alexander, 1999; Kiyak, Namazi & Kahana, 1997). In reviewing literature written by the proponents of patient-centred care, authors suggest workers reflect on client need when delivering service, but few recommended clients actually be consulted. To truly give power to clients, workers will have to give up their "position as ... benefactors" (Pinderhughes, 1983, p. 337) and then empowered workers or clients may feel comfortable in raising difficult questions in health care (Gitterman & Miller, 1989).

Direct care professions are shaped by differential power advantage, through their selection of workers, and the workers' selection of clients, the persons who fit the definition required by dominants — those who fit society's norms. Where the staff/client relationship is the main work technology, and line staff work behind closed doors, even low level staff have some discretion (Hasenfeld, 1983, Lipsky, 1980). Regardless of their actual discretion and power, workers may feel second class and believe they have insufficient power to face those with system power at their places of work (Hugman, 1991).

Individual decision-making power at recipient of care level.

Older adults who are recipients of care experience power-over as unidirectional, at times becoming abusive. While four percent of older adults have reported abuse overall (Health & Welfare Canada, 1993, p. 7) the rate of abuse within institutions is unknown. Elder abuse is defined as occurring within relationships of dependence (Advocacy Centre for the Elderly & Community Legal Education Ontario, 1996). The prevalence of elder abuse, the struggles with issues of dependence that workers witness, and the multiple levels of power, advantage and disadvantage, make questions of power differentials highly relevant for recipients of long-term care.

The nature of formal and informal bureaucratic organizations, client need, power-over, knowledge about, and secret language of health care and bureaucracy create and reinforce diminished status, autonomy and advantage of clients (Ferguson, 1984). Consumers, though, because of their payment for service, have more power and less dependency than clients; the non-paying client must demonstrate his or her eligibility for subsidized service. Even so, the manner in which we select and invite consumer participation can be another way of reinforcing disadvantage and assuring responses do not challenge dominants (Aronson, 1992). Each group — clients, workers and administrators— seeks an image compatible with the organization in order to maintain their relationship with it (Ferguson, 1984). Clients who understand bureaucracy, or can assess worker competence through consumer driven

feedback loops, have increased power and support because of worker accountability (Birenbaum-Carmeli & Carmeli, 1996; Sarri & Hasenfeld, 1978; Tanenbaum, 1997).

Life itself is defined as a form of power (Boulding, 1989). We might question whether power varies with one's connection to life or with one's closeness to death. In a similar way, when we assure that those with physical health knowledge maintain expert status, the dominance of science and technology is assured; clients who are not in the hospital proper are disadvantaged. If resources are distributed on the basis of this dominance or one's connection to life, those who require simple comfort aids, such as the frail elderly, will be left with little power and few resources (Hugman, 1991).

Clients defined by their disease struggle to retain what little power they have (Hugman, 1991; Lee, 1997), but their dependency is nurtured by connection to the caring agency (Ferguson, 1984). When mechanisms controlling unequal access and the controllers are invisible, it is easy to believe all have access (West & Fenstermaker, 1995). When workers enforce bureaucratic rules and other workers follow their instructions, they collude to reinforce the disadvantage that flows from the rules (Ferguson, 1984; Hugman, 1991). The worker teaches the clients the behaviours which are acceptable and defines expected compliance. As clients spend more time in a health facility, they learn to be passive, compliant and helpless (Raps, Jonas, Peterson, & Seligman, 1982). "Medical staff responded more favourably to patients who

were submissive, uncomplaining and respectful. In doing so, they reinforced a professionally sanctioned conception of the good patient" (Hasenfeld, 1992, p.17). As clients seek such an acceptable image, they also avoid help-seeking behaviour to protect their current level of power (Lee, 1997). Labels further develop the image and the accompanying self image which in this case might be paranoid, cognitively impaired or incontinent (Hasenfeld, 1992).

Relations of dependence and autonomy between clients and organizations may flow in one direction or be interdependent. Interdependence increases only if organizational needs are similar to client attributes, influenced by gender, race and class (Gonyea, 1995; Sarri & Hasenfeld, 1978). If the client trusts the organization, however, the organization gains control and client compliance; and when the goals of the two are compatible, trust increases. The client with resources has more power, particularly where the organization needs those resources, and where beliefs are compatible, interaction may be mutually desirable (Sarri & Hasenfeld, 1978). The organization may protect itself through demands for medical testing, documentation of service provision and rigid rules (Hasenfeld,1992).

The dependent person must be willingly dependent as care providers expect them, or their substitute decision makers, to understand information and to use good judgement in consenting. When clients are aware of the discretionary decisions made by workers they may seek the worker's favour, or the worker may overstep boundaries, or even become abusive. Legal sanctions

against abuse are less effective where direct care contact is frequent or where care is personal (Disch, 1998; Hasenfeld, 1992). Involuntary clients coerced to accept help are at a greater power disadvantage and may resist the care to which they have formally consented (Disch, 1998; Hasenfeld, 1992).

There is another side, however, to differential power at the client level. Those on the margins do have some power - originating in the guilt of those in charge and in the client's ability to understand those in charge. In a culture of power-over, competition, control and authority (Harlos, 1995), these survival mechanisms of the vulnerable will be "ignored by the powerful at their peril" (Janeway, 1975, p 105-109). At a macro level, Jane Aronson (1994) has written about the involvement of elders in government policy development and change. She points out the bureaucracy expects elders to "translate their experience into the vocabulary of administrative structures and procedures...when what they actually want is more control over their own lives" (p. 12). She clarifies while involved elders may have an opportunity to speak, they are not given an opportunity to truly be heard or to define their actual needs in the process; they are restrained from what might have been their contribution (Aronson, 1994).

This summary of organizational power literature represents only a fraction of what has been written about power, decision-making and long-term care organizations. However, my primary interest in power within human systems, operationalized through decision-making, is in theoretical constructs

that consider "both client attributes and organizational variables and the interaction between them as determinants of client-organization relations" (Sarri & Hasenfeld, 1978, p. 185). Within the context of client characteristics and organizational variables, my work with disadvantaged older adults has suggested a theoretical frame to integrate an unequal multi level relationship of decision-making power or lack of power between the long-term care organization, its workers and managers and the older adults who were recipients of their service.

This power literature documents that the development of a large bureaucratic structure has been primarily the result of the desire to control; certainly in the long-term care settings studied, control, and lack of control, were apparent (Weber, 1947). Systems of care engaged providers and recipients of care — primarily women — who lived with, and more importantly without, decision-making power and control in their daily lives in an age- and gender-biased society. The importance of matters of power and powerlessness in the lives of older adults is reinforced by literature that reveals similar dynamics of decision-making power held by organizational employees who provide the care. This study as a whole asks whether similar parallel processes of decision-making power as those endured by residents also occur at various institutional levels. The next section of the dissertation provides a rationale for my use of specific elements of chaos theory as a theoretical base from which to understand the suggested parallel nature of long-term care decision-making

power.

Chaos Theory

Like the organizations defined by Weber in 1947, formal bureaucratic health organizations, including those offering long-term care, reflect the machine metaphor that dominated during the industrial age. Like a machine, the health-care bureaucracy implies a whole can be understood by learning about its parts, order can be maintained through a hierarchy of functions, and over time one must be watchful and reassess for any deterioration that may have occurred (Prigogine & Stengers, 1984). Bureaucratic long-term care organizations develop and implement risk management and quality control strategies that seek to understand and control the entirety; the hierarchy of staff positions, levels of care and stages of cognitive deterioration assist in the maintenance of control; and ultimately, watchful internal and external agents assess for risk. Both the principles of Weber's bureaucracy and Newton's laws of the natural world identify and value similar principles: determinism, stability, orderliness, uniformity and equilibrium (Kuhn, 1962; Prigogine & Stengers, 1984; Weber, 1947).

But the world has changed. The proliferation of information, technological advances and fast-paced change are catapulting the natural world, its people, and its human organizations into a new reality of cutbacks, restructuring and an on-going quest for information at incredible speed (Greenwood & Lachman, 1996; Peters, 1987).

Against this backdrop of change, chaos theory has developed from the world of physics, conceptualized by Prigogine and Stengers (1984) and Mandelbrot (1983). The theory's fundamental premise is that creative new entities or ideas arise from chaos (Gleick, 1987). In contradiction to the stability and order held as fundamental conditions essential to the machine metaphor and also to Newton's natural laws, the creators of this new theory have described its *non-machinelike* elements: non-linearity, multiple components, a labyrinth of feedback spirals, an energy that is self organizing, openness to the surrounding environment and time irreversibility. Prigogine and Stengers (1984) identify a "point of bifurcation" (p. 161) that occurs "far from equilibrium" (p.140)..." on the edge of chaos", where "a dynamic tension exists" in the system (Zimmerman, 1996. p.3). It is out of this ambiguity, urgency and pressure that something new and creative can emerge. While studying weather patterns, Lorenz (Gleick, 1987) added another interesting concept to the chaos ideas already defined by the theory's creators — the butterfly effect. This phenomenon allows the possibility that a seemingly insignificant weather event in one part of the world may create, with the passage of time, a huge reaction continents away.

Most human beings know intuitively chaos is a part of being human; as such, it must be part of human systems as well. In his classic book, *The Structure of Scientific Revolutions*, Thomas Kuhn identified even in the development of novel scientific ideas that "anomalous experiences..., by evoking

crisis, prepare the way for a new theory. " (Kuhn, 1962, p. 146). This emerging theory of chaos leads us to a better understanding of science, which is itself an open system embedded in society, with a spiralling feedback of learning and ever expanding knowledge. In our complex human world where fast-paced social changes, disorder and nonlinear relationships co-exist alongside the human search for power and control, (in street gangs, in the large corporations and bureaucratic health and long-term care organizations) chaos theory seems an ideal lens with which to analyse decision-making power.

While many elements of this emerging theory can be applied to my work, the chaos concept most relevant to this study is the fractal: a complex, random shape where "the degree of irregularity remains constant over different scales" (Gleick, 1987, p.98; Mandelbrot, 1983). Fractals give form to chaos, with comparable complex irregularities on all scales. These shapes defined by the creators of chaos theory replicate the complexity of shapes in our natural world such as the regular repeating patterns and shapes found in a fern, an evergreen tree or a human kidney. Though these shapes appear random at first, closer examination finds repetitive patterns that exist on all scales. Similarly, although an organization may seem disorganized and chaotic to the untrained outsider, there may be an order and congruity within organizational decision-making patterns of power (Zimmerman, 1996). The concept of decision-making power is certainly relevant in human organizations at all levels, but do similarities exist at all levels?

The main elements of chaos can be applied to human organizations as well as they can be applied to humans themselves. The creativity that follows a tension at the "edge of chaos" (Prigogine & Stengers, 1984; Zimmerman, 1996, p.3), the complexity, non-linearity, and the spirals of communication feedback (Gleick 1987; Nonaka, 1988; Prigogine & Stengers, 1984; Tetenbaum, 1998; Zimmerman, 1994) are all found at the core of human organizations. Where the old style of management imposed order from the top down through a hierarchical structure, management by objectives and strategic planning, the definition of equilibrium and stability are seen as signs of organizational success (Zimmerman, 1996); yet, some writers have maintained that creative potential can be stifled as a result of these ordered, machine-like, and non-chaotic systems (Ferguson, 1984). While organizational planners and strategists have defined clear processes and policies to control the future evolution of their organizations, even these experts in organizations cannot always predict the future; chaos theory explains some of the uncertainties and randomness of organizations (Zimmerman, 1996).

On the other hand, in organizations that might be managed according to the principles of chaos the valued worker would learn quickly but would not be uncomfortable with ambiguity (Tetenbaum, 1998); work would be de-bureaucratized and include more horizontal and fewer vertical interrelationships (Peters, 1987). As managers and workers managed change and broke down barriers, order might arise from the constancy of change and the

broader perspective that this sort of change would engender in the aware observer or participant. Though such a system would be unpredictable, many possibilities could become visible with the new lens of chaos theory (Zimmerman, 1994).

This chaotic organization would be non-linear, multifaceted, multi-directional and open to its context, not at all resembling the machine of the industrial age. Continuous spirals of information feedback and a flow of human, communication and technological energy would move this system to self organize (Prigogine & Stengers, 1984; Zimmerman, 1996, p.3). We can see and predict the power in these spirals of feedback and communication flow sometimes in the impact of a simple memo as it floats through an organization, demonstrating Lorenz's "butterfly effect" (Gleick, 1987, p.21). In the chaotic organization, power and control would result from individuals' adaptation to continuous uncertainty and from their ability to build connections with other individuals and the environment itself (Boulding, 1989). It would be as managers share information that they and others would be enabled to develop the creativity that might, in the end, control the chaos. Like the fractal, such qualities of the organization and its individuals would exist at all levels (Zimmerman, 1996).

The fundamental premise of chaos, the belief that order and creativity follow and rise out of uncertainty, is compatible with many aspects of our natural, human and organizational world. During times of crisis management,

with pressure to downsize and make rapid change, power structures are questioned and bureaucratic managers often try to regain control through rationality and planning strategies (Prigogine & Stengers, 1984; Tetenbaum, 1998; Zimmerman, 1996). Managers who follow chaos principles, on the other hand, would ride the waves of change during the crisis at the same time as encouraging staff autonomy, and giving them the power to develop their potential. In summary, chaos is a theory of interrelated systems and fields, similar to systems and field theory, but chaos takes the concepts of interrelatedness further.

Chaos theory does pose a challenge to traditional organizations when it places creativity in juxtaposition and competition with the formal hierarchical power that maintains order and control. While traditional long-term care managers manage by objectives, plan strategically and value stability, funding cuts and escalating costs together with predictions of increased demand based on demographics are tipping the balance and creating chaos in the system (Longest, 1984). As those with power try to maintain order and prevent chaos, others might argue these techniques, particularly in bureaucracies, are dysfunctional and lack creativity (Peters, 1987). One must question whether creativity can ever survive in such controlled systems. Such a question challenges the essence of traditional management and control, and supports chaos (Tetenbaum, 1998).

While not necessarily referring to chaos theory, other theorists also link power with the change that permeates today's world. For example, when

organizations seek control of knowledge using management techniques such as total quality management, they translate knowledge control into rational processes, but dissipate expert power at the same time. Reed identifies this power as an outcome out of interchanges of "social constructions and structural constraints" (Reed, 1996, p. 578). The power of individuals to change organizations is based in trust. However, when change is attempted a tension between group and individual interests often results (Frohman, 1997); in a context encompassing a struggle between competing health-care interests trying to control and carry out their ideas, there may be little trust (Light, 1997). Picken and Dess (1997) recommend problems arising from rigid and controlling management methods may be dealt with effectively through flexibility and the sharing of information; Goldstein (1995) goes further in suggesting what he calls a "far-from-equilibrium" approach to dealing with the entrenchment that often accompanies change. The linking of power by these authors to change and disorder provides further justification for chaos theory in the analysis of organizational decision-making power. Humans and the organizations they construct are complex, multi-dimensional entities using power and the decisions of the powerful to create and react to changes in their environment.

Several factors particular to organizational decision-making and connectors salient to chaos theory require further definition: boundaries, the both/and concept and the notion of a similar parallelism. Although organizational boundaries may appear rigid and closed, there are few closed

systems, even in the scientific world. Most organizations are open and creative, closely tied to their environment — compatible with the systems described by chaos theorists. The "edge of chaos", "far from equilibrium" and its point of dynamic tension could well describe a social system undergoing change (Prigogine & Stengers, 1984, p. 140; Zimmerman, 1996, p.3). Inherent in this tension are boundaries (Tester, 1993), between individuals, between aspects and stages of life and between organizations. In maintaining boundaries, decisions are made, and some gain power while others lose it.

Consider the implications of replacing fixed boundaries with the more permeable, flexible boundaries of chaos. When we put traditional management methods against those proposed by chaos theorists where staff are given responsibility and managers "manage changeability" rather than merely change itself (Zimmerman, 1996, p. 16), trust is critical. Managers must trust that something better is possible. And trust requires that boundaries be flexible. Such an evolution to flexible, permeable boundaries would be maintained by participants' commitment rather than by the power of those in charge. Order and chaos can exist simultaneously in organizations where those with power are flexible and open to real change (Helgesen, 1990; Tester,1993). The way of thinking compatible with chaos accommodates order and disorder simultaneously. Perhaps a choice between options, then, is unnecessary.

If the true state of the natural and human world allows for co-existence of order and disorder, irregularity and stability, simplicity with complexity,

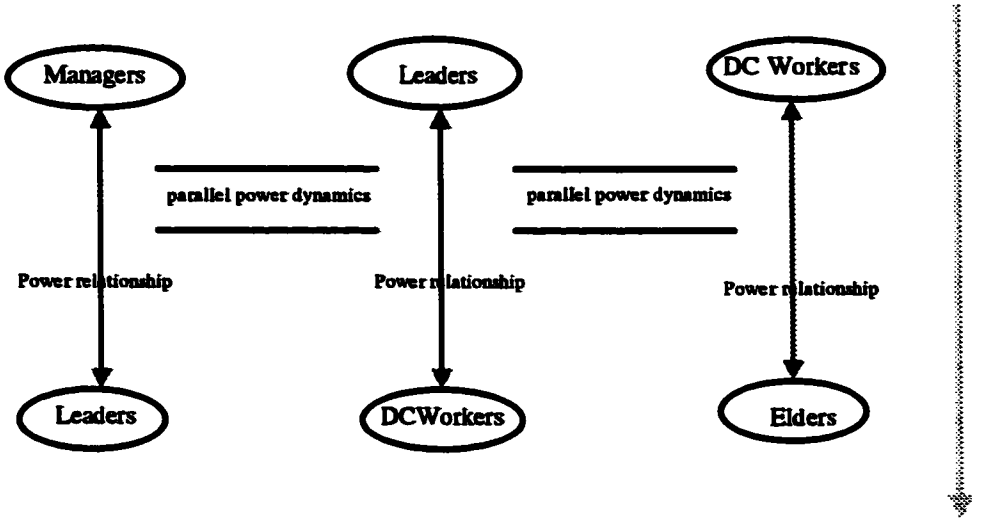
closed systems with open systems, perhaps then organizations can accommodate a similar duality. This duality is replicated in power relations as the individual has more informal power and control at the same time as he or she relinquishes much of his or her previous formalized power — and this power is operationalized through decision-making processes. The changing human system will become both more understood and more chaotic simultaneously. A similar both/and argument might be posed about models of health care where we might imagine a system allowing order and planning to coexist with unexpected turns and unplanned innovation.

Multiple possible parallels may be suggested as order and disorder are considered simultaneously. At the macro level there is the possible parallel between the organization and the client — both are open systems engaging multiple exchanges of resources, information and energies, each striving toward survival and goal attainment (Sarri & Hasenfeld, 1978). Likewise, passivity and compliance are respected behaviours in health care for both workers and clients. As the "good" patient quietly awaits her care, the "bad" patient perhaps argues, presents an independent self and attempts to control the care. Similarly, direct care workers are compliant to organizational demands, but also reinforce the power that the system holds over its clients. These workers increase client vulnerability as they themselves comply with the organizational power because of their own vulnerability. Within the hierarchy of health care, the structures that deliver long-term care may themselves be disadvantaged in a similar way,

when compared to other health organizations, to the ways in which old female clients are disadvantaged when compared to younger health-care recipients. This disadvantage occurs in a context where most of the recipients of care, workers, lead workers and managers are female, and many are old.

The literature about organizational power elucidates power differentials that may exist in care giving environments; this power is held and

Figure 2: Initial Theory Postulation



operationalized through the decisions that occur in these environments. These decisions are the focus of my study. The focus of this study, as demonstrated in

the accompanying diagram, is on the possible parallels that exist in decision-making patterns particular to staff groups and care recipients in long-term care (Figure 2). Just as the fractals of chaos theory define the base nature of chaos through similar irregularity on all scales, this study seeks to understand whether decision-making power in long-term care is similarly replicated on all scales, that is in the relationship between managers and staff leads, between staff leads and workers, and between workers and residents.

IV: Methodology

My practice-based experiential knowledge, augmented by the literature reviewed here, gave rise to my initial organizing question. The principles of chaos theory and fractals gave form to the question and led to the hypothesis that was illustrated in the diagram at the conclusion of the previous chapter. Both quantitative and qualitative methodology were used in an exploration of the similarities in the decision-making power dynamics experienced at various levels in long-term care.

Quantitative data were gathered through a questionnaire package that reflected decision making from residents, workers, staff leaders and managers in one particular long-term care facility. Qualitative information was gathered from participant responses to open-ended questions, participant observation focused on decision-making behaviours by residents of a secure unit, interviews with a small number of key informants at different organizational levels were recorded and, finally, primary documents such as policy manuals, philosophy statements, and program plans were reviewed. What follows is a detailed description of the methodology used, beginning with a statement of the research question and hypothesis. In each segment of this chapter, quantitative information has been presented first, followed by qualitative.

The Research Question and Hypothesis

The literature revealed multiple aspects and layers of decision-making power in organizations. When literature was considered jointly with the

knowledge that comes from social work experience as it was seen through a chaos lens, the research question and hypothesis evolved as follows.

Research Question

> Is there a relationship between the decision-making patterns and differentials that occur (1) in the relationship between senior managers to front line managers, and those that occur (2) in the relationship between front line managers to direct care and non-direct care workers, and those that occur (3) in the relationship between direct care workers to clients in long-term care facilities?

Research Hypothesis

> The decision-making patterns and differentials (1) that exist between senior managers and front line managers, the decision-making patterns and differentials (2) that exist between front line managers and direct care and non-direct care workers, and the decision-making patterns and differentials (3) that exist between direct care workers and clients in long-term care facilities will be similar.

In this study, the reciprocal personnel groups that are compared, that is, managers and leaders, leaders and direct care workers and direct care workers and residents, will be referred to as dyadic units. The term dyad is defined as "two individuals or units regarded as a pair" (Canadian Dictionary of the English

Language, 1997, p. 428). The use of dyadic unit is not intended to describe what the literature refers to as dyad research (Havens, personal communication, 2002), but rather the comparison of decision making power between the reciprocal personnel groups involved in each study dyad.

Research Site

The site chosen to investigate the hypothesis was a not-for-profit, municipally run Home for the Aged that was a member agency of Ontario Non Profit Homes for Aged Association. A member of senior administration of a regional level of government was approached and the main research goals were discussed. This manager referred the query to the administrator of a long-term care facility in the region and he in turn agreed to support the study. This particular home was selected in part because of the willingness of the administration to participate in the study, and in part due to its status as a non-profit home in a region of Ontario known for its excellence in long-term care. This long-term care facility provided continuous care of older and disabled individuals and special care for persons living with dementia.

Population and Respondents

The specific sample for this study was drawn from among the staff and residents of this facility: direct care and non-direct care workers, front line and senior managers and impaired and non-impaired residents. All staff and managers were offered the opportunity to participate in the study with the exception of those members of staff who were on extended leave at the time of

the study. The home administrator introduced the study to staff and granted permission for staff to complete the questionnaire during work hours.

The social worker in the facility provided a list of legally capable residents who were able to complete a questionnaire. All residents identified as legally capable to answer the questionnaire were offered the opportunity to participate. The researcher assisted these residents in completing the questionnaire as needed. In addition to answers to the questionnaire itself, any qualitative comments made by the participants were included in the field notes.

Development of Instrumentation

Quantitative Instrumentation

Variables.

A standardized decision-making questionnaire previously used with staff of a long-term care facility formed the base of the larger instrumentation package employed for this study. In addition to the scale and its applications, several additional scaled questions, demographic questions and finally, open-ended questions comprised the package. These other variables have been described later in this section. Staff were invited to complete self administered questionnaire packages; residents were assisted in completing a shorter questionnaire that used some of the same questions.

Questionnaire and subscales.

Among the instruments reviewed, the one chosen as most applicable to several levels of staff and of possible application to residents, was Staff

Involvement in Decision Making (Kruzich, 1989). This scale, referred to from here as SIDM, was selected on the basis of being previously tested in a long-term care facility and on the applicability of its items to issues of decision making among staff and, potentially, residents. Kruzich developed this scale for use with long-term care staff from two other scales used in mental health facilities, the Buffam and Holland scale (The Employee Influence Scale) and the Petchers-Cassell & Holland scale (Participation in Treatment). Her results indicated "a high level of internal consistency estimates across all groups of staff" (Kruzich, 1989, p. 47) with Cronbach's Alpha scores ranging from .84 through to .94 depending the role of the staff persons answering the questionnaire. The scale was comprised of 27 items with a 5 point Likert style ranging from 0-5 indicating the degree of influence respondents felt they had in relation to the item. The standardized questionnaire had two subscales, one related to aspects of care (15 items) and one related to organizational questions (12 items). Four items related to care were added, creating a 19 item Care Subscale.

This standardized questionnaire was adapted for use with residents by changing the wording for clarity. For example, the question "In general, how much influence do you have in placing restrictions on the activity level of residents?" used with staff respondents, was changed for use with resident respondents to "In general, how much say do others have in placing restrictions on your activity level?" While staff answered the entire questionnaire, residents

answered only the Care Subscale.

As previously noted, this Care Subscale as it was originally conceived was altered with the addition of four items. Both staff and resident respondents answered the amended Care Subscale with Added Items but, in the case of resident respondents, the questions were altered in the same manner as described earlier. The following items were added to the original Care Subscale used with staff through a Likert type scale ranging from 0–5 indicating the degree of influence they felt they had.

a) In general, how much say do you have in deciding the toileting schedule of residents?

b) In general, how much say do you have about the residents' clothing choices?

c) In general, how much say do you have about the food selection for specific residents?

d) In general, how much say do you have about when the residents wash, shave, brush their teeth and comb their hair?

A second variant of the standardized scale was developed to obtain information about staff members' perceptions of their superior's decision-making power, called Staff Involvement in Decision Making–Perception of Superior (SIDM–PS). Staff were asked to select someone at the level of a superior and answer a series of questions with *that person* in mind. For example, the question "In general, how much influence do you have

in placing restrictions on the activity level of residents?", reflecting the respondent's perception of their own influence, was changed to "In general, how much say does *that person* have in placing restrictions on the activity level of residents?". These items reflected the respondent's perception of the superior's influence.

Other related questions were developed and added to this base. These additional questions, both qualitative and quantitative, were integrated within the standardized instrument for ease of administration and clarity for participants. However, the questions that were added to the standardized questionnaire were separated out during the subsequent analysis. In this study, patterns and differentials of long-term care decision making were revealed through the individual's perception of their own decision-making power in the SIDM Scale and its variants. Their understanding of the decision making that occurred at other organizational levels was revealed through the scale variant and other individual variables related to their perception of someone at the level of their superior. A similar, but more limited measure of participant decision-making power was administered to identify residents' perceptions about decisions made about their care by others, and the decisions made by residents themselves.

Other individual variables.

Additional individual variables were developed to demonstrate other aspects of decision-making patterns including: the numbers and perceived importance of decisions made about residents, the numbers and perceived

importance of decisions made about staff, the numbers and perceived importance of decisions made about self, the individual's own perceived influence and the perceived influence of the superior, and the numbers of people dependent on decisions made by the individual. Two additional quantitative factors were used to further increase the credibility of the study. The home's philosophy emphasized teamwork, loyalty, the value and dignity of all members of the home's community and a focus on customer needs. As such, the perceptions of individual staff members of both their own application and the application by others of the home's philosophy provided auxiliary clarification of the results.

Demographics.

The literature suggested age, gender, income, ethnicity, work tenure, education, type and schedule of work and role in the organization would perhaps be indicators of decision-making influence and power. Data about these attributes were gathered as part of the package. Other factors that were organizational in nature have been excluded since this study examines only one facility.

Qualitative Instrumentation

Several questions in the package were open-ended and asked staff and resident participants who completed the questionnaires for clarification to previously asked quantitative questions. Qualitative data were gathered from cognitively impaired individuals only via participant observation of those residents of a secure unit for whom their substitute decision makers had given

consent. The unit for observation was selected by the administrator of the home. The behaviours of all persons present in the common room on the unit while the researcher was in attendance were observed and recorded. Four visits were conducted at different times of day. An Observation Schedule of Decision-Making Behaviours was developed and subsequently used to count observed decision behaviours by residents. A second rater was present during one observation session to ensure inter-rater reliability. Follow up interviews were conducted to clarify results after analysis. Persons were selected for interviews according to both their availability and their knowledge about the issues where clarification was sought.

Collection of Data

Procedures for Accessing Population

Several preparatory steps were initiated prior to the data collection process itself. First, approvals were required. Following the proposal acceptance by the Dissertation Committee and ethics approval (Appendix A) by the Ethics Committee of Wilfrid Laurier University, the next step was to seek approval for the proposal from the Regional Government in the region where the selected home was located. The home administrator also had input to the plan, assisted with the resolution of process issues and reviewed and approved all documents and letters prior to distribution. Second, an initial orientation to the home and attendance at several events as a "home volunteer" gave credibility to the project, allowed access to information, protected residents' rights and gave

stakeholders the opportunity to become comfortable with a newcomer to the home. Third, information meetings were held with managers and union leaders both as a group and as individuals where the research plan, goals and processes were explained. In addition to the formal information statement (Appendix B), an information article was printed in the home's newsletter that was distributed widely to staff, residents and families.

Ethical issues.

Because part of this population of study would be classified by the Tri-Council Policy Statement for Ethical Conduct in Research Involving Humans (Tri-Council Working Group of Medical Research Council of Canada; Natural Sciences and Engineering Research Council of Canada & Social Sciences and Humanities Research Council of Canada. 1998, p5.4) as either "incompetent to consent for themselves", or on the edge of this classification, ethical research principles took on more importance than might be typical. Therefore questions of vulnerability, substitute decision-making, competency and informed consent took on legalistic implications. In such a context where many residents lack capacity, decisions made by substitute decision makers have been accepted in law (Franzi, Orgren & Rozance, 1994). For this reason most research studies have used data from proxies rather than directly from those individuals who are cognitively impaired.

But where proxy decisions impact daily living and even life and death, direct resident input may offer another potentially valuable source of

information, regardless of the challenges posed by frailty and cognitive impairment. In addition, Kruzich reported an absence of empirical research about perceived control by nursing home residents and staff (Kruzich,1995). Because this study was of decision making, and because one of the primary impacts on the lives of those who are cognitively impaired may be a loss of decision-making power, it was important to gather decision-making data directly from these residents, in this case, through participant observation. However, their decisions would not be considered legitimate in legal or care domains.

Informed consent.

Informed consent was difficult to obtain with both residents and staff, though for different reasons. In the case of staff, several eligible staff members were concerned about confidentiality and about signing the informed consent form itself, although they spoke of having no hesitation in actually completing the questionnaire package. Several persons did not participate because of their fear that they might be identified in some way. Those who decided to participate may have tended to answer differently from those who did not participate in the study; this tendency introduced the possibility of sampling bias into the study. For example, staff who did not complete the questionnaire may have had more positive, or negative, perceptions about their decision making power in the organization than those who did participate.

For previously mentioned reasons, questions of consent were of foremost

importance for potential resident participants. The informed consent statement was sent to each potential participant, or their proxy decision maker, as a part of their package. This informed consent statement included information about confidentiality, the absence of deception, the participant's right to withdraw at any time, and the researcher's contact information (Appendix C). In some cases, the signed forms were not returned by proxy decision makers of residents on the secure unit for many weeks. Follow up phone calls allowed the researcher to answer family members' questions about the study.

Quantitative Collection

Prior to approaching the site to begin the administration of the questionnaire packages, questionnaires were pre-tested with six individuals of varying ages. A small number of editorial changes were made as a result of the pretest prior to administration of the instrumentation package to all participants.

Potential staff participants then received information and the questionnaire package itself attached to their pay stubs and the administrator of the home sent an introductory letter to each unit. Potential resident participants received information and the questionnaire package during face to face meetings. In the case of proxy decision makers for individuals residing on the observation unit, information was distributed by direct mail to those persons identified as proxy decision makers. Each package included the appropriate version of the questionnaire, the informed consent statement and form for signature and an information letter on Wilfrid Laurier University letterhead (Appendix B). A

stamped return envelope was included for proxy decision makers. Data collection boxes were established in the main lobby of the home with one box set aside for the questionnaire packages (Appendix D) and another set aside for the signed informed consent. A sign indicated the boxes would be emptied only by the researcher.

Participant packages included the researcher's phone number and a note encouraging them to ask questions about the project. Their confidentiality was protected, both from individuals inside and outside the home; also the name of the home itself was not revealed. Participants were fully informed about the project and the subsequent confidential storage of data. Follow up flyers were distributed and visits to the home conducted during each shift on weekdays and during weekends to assure all participants had the opportunity to ask questions and to participate.

Qualitative Collection

In order to clarify and enhance understanding of quantitative data, several methods of data collection were used. This triangulation process allowed for the confirmation of the findings across several methodologies and also allowed for some decision information collection from individuals who were not considered legally responsible (Denzin & Lincoln, 1994, p.214-215). These methods included the addition of open-ended questions to the quantitative questionnaire, participant observation of decision behaviours among residents on a secure unit, and key informant interviews.

Open-ended questions.

All staff and resident participants who completed the quantitative questions also had the opportunity to add comments regarding several areas of questioning through the use of open-ended questions such as "Please elaborate" and "What words come to mind when you think about the decisions you make on the job? (Appendix D). The addition of this method enriched the information available from the variables identified (Appendix E) in the previously discussed quantitative methodology.

Participant observation on special care units.

A location was established on a selected special care unit where residents spent their time when they were not in their own rooms. A desk in an activity room with a window looking into the public area, just adjacent to the public area, was the observation location. It allowed observers to both watch and listen to activities in the public area in a relatively non-intrusive manner (Denzin & Lincoln, 1994, p.249). On the first observation visit, an Observation Schedule of Decision-Making Behaviours was developed including all behaviours that were observed indicating a decision was made by either the resident or someone else on the resident's behalf; this tool was subsequently used to count observed decision behaviours by residents. Qualitative field notes regarding the behaviours were penned. Decision behaviours by residents who lived on one of the secure units and all other persons who were in the common area during the observation were counted and recorded. When a resident entered for whom

permission to participate had not been granted, the researcher left the area. This occurred on two instances. Four visits were conducted lasting from one to three hours in duration at various times in the day and early evening. A second rater was present during one observation session to ensure inter-rater reliability.

Key informant interviews and document review.

A limited review of general institutional documents was conducted to allow for the development of a general institutional profile including a brief description, the levels of care provided, the number of beds, services offered, major payers and number of employees in each identified staff group. Key informants in the home were identified, both by availability and by the individual's role in decision making. Unstructured interviews were conducted and recorded after the analysis of other data. Two grande tour questions were posed to each of the three informants based on issues which surfaced during the process to that time (Glaser & Strauss, 1967). Following the dissertation defence, a summary of the results will be sent to interested persons.

Analysis of Data

Quantitative Analysis

The quantitative analysis consisted of descriptive, bivariate and multivariate analyses. This quantitative analysis has been presented first. Analysis of qualitative data and of interviews with key decision makers was used to reflect on quantitative findings and therefore the qualitative analysis follows the quantitative findings. The organizational profile used both descriptive

quantitative analyses and document review data. This combination of various kinds of data was necessary in order to achieve the desired profile and comprises a separate section in the results.

Descriptive analysis.

This profile of the organizational population has been replicated to develop a profile of the sample using tables of frequency distributions of gender, age range, ethnicity, income, work patterns and tenure of the sample as a whole and of the subgroups within the sample. The subgroups of personnel in the sample have been further defined according to their work designation and profession, as have been response rates both within the subgroups and in the sample overall.

Bivariate analysis.

All tests run in the bivariate and multivariate section were based on a theoretical understanding of decision making in long-term care, and on specifically related organizational power issues. Prior to beginning the bivariate analysis, various tests were run on the data to provide the information necessary to ascertain whether there were violations within the data that would discourage the running of subsequent tests. The scales and subscales have been carefully segregated to prevent the use in the same test of two scales that were not independent of each other. The bivariate analysis was conducted on all participant group data simultaneously and also where only managers and leader data were used, where leader and direct care worker data were used and finally

where direct care worker and resident data were used.

A correlation matrix demonstrated correlations between continuous variables, and thereby enhanced understanding of the applicability of the theoretical constructs and indicated the feasibility of further multivariate investigation. Both Pearson and Spearman (rho) correlations were used, depending on the distribution of the data. Independent T-Tests compared differences in scores on those decision scales that do not violate assumptions, between specific participant groups. These bivariate analyses then, provided a beginning understanding of the various relationships between distinct pairs of variables such as those noted and guided subsequent multivariate analysis.

Multivariate analysis.

The data were then assessed considering several variables simultaneously. Multiple regressions were run using each decision-making scale that did not violate the key assumptions that must be met before running regressions. Those variables entered into the regression were those that were theoretically linked to decision making. MANOVA and Univariate analyses were considered. However, the absence of a sufficient N level for some groups and cells precluded meaningful findings using these tests. A Path was also considered, but as the regression results were entered, there were insufficient variables involved to construct a meaningful Path.

Qualitative Analysis

Qualitative data were transcribed, themes were found and main concepts

derived. Field notes were recorded and transcribed from the responses to open-ended questions, from the participant observation field notes and behaviour counts, and from the follow up interviews with key informants. These interviews based in both quantitative results together with qualitative themes took the form of semi-structured interviews conducted with the CEO, Director of Nursing and Director of Social Services. Those interviews further verified and/or explicated data.

Organizational profile development.

Basic demographics related to the respondents and also to the home population as a whole were gathered from each respondent and from the home documents. The home philosophy used in the quantitative instrumentation came from these documents. This material was subsequently analysed and presented to develop the relationship between the population as a whole and the respondent group. Documents reviewed included volunteer program training manuals, operational flow chart, staff lists, resident lists and staffing complement information. The profile provides a quick snapshot of the home where the research took place.

V: Quantitative Results

This chapter and the next give a detailed breakdown of the research results under four main categories: descriptive analyses, bivariate analyses, multivariate analyses and qualitative analysis. Quantitative results reflected here include the analysis of several versions and subscales of the standardized scales, individual quantitative questions and related tables.

Descriptive Data

Demographics

Organization profile.

The home was set near water, on the outskirts of a pleasant community in southern Ontario, surrounded by gardens, mature trees and patios used by residents, staff and families. This facility was like many other regionally supported homes of its age and mandate; it was not a new building, but was built during a time when residents who had semi private rooms were fortunate; only a few had private rooms. The building had a welcoming atmosphere internally as well as externally; one particularly unique feature was that each resident room had an entrance that resembled a front door of a single dwelling, complete with a small shelf where residents could place a bouquet of flowers, a favourite memento or a family photo.

The home had 225 residents. Care was provided for residents living with various forms of dementia, on four secure, special care units with a total of 104 residents. The remainder of the residents were cared for in three "Age in

Place", continuous care units. Staff reported either directly or indirectly to the home Administrator, who reported to the Assistant Director of the Seniors Division of the Region. The home had a residents' council, a volunteer auxiliary and a volunteer coordinator and program. The staff complement included 171 identified full or part-time positions augmented by a team of casual workers and also by other workers who were on leave at any one time. This work team was made up of managers, leaders, direct care workers and non-direct care workers. Workers and residents were primarily white females with modest levels of education. What follows details the descriptive analysis of data collected.

Respondents.

Of a total of 230 staff who filled the complement of 171 positions, 200 were eligible to participate in this small study; 31 staff members were on extended leave for medical or other reasons at the time of the study. From those eligible staff members remaining, 83 (41.5%) completed the questionnaire package (Table 1.0). Among residents of the home, 51 residents were identified as legally capable, and therefore eligible to answer the questions; 41 (80.3%) of those eligible residents agreed to participate and signed the informed consent form (Table 1.0). The overall eligible population, including both staff and residents, was 251 persons from which a total of 124 (49.4%) responded. Residents who participated in the observation portion of the study were drawn from a total population on the unit of 30 residents; from these individuals, 28

(93.0%) of the proxy decision makers agreed their loved one could participate. Each observation included between 5 and 11 of these residents who were in the public area during an observation.

Groups.

Respondents initially identified themselves as filling one of ten roles within the

Table 1.0: Population and Sample

Demographics	Number Available Population N (% of total N)	Sample n (% of total n)
Staff Groups:		
Managers	20 (10.0%)	14 (16.9%)
Leaders	39 (19.5%)	22 (26.5%)
Direct Care Workers	64 (32.0%)	31 (37.3%)
Non-Direct Care Workers	48 (24.0%)	14 (16.9%)
Casual	60 (30.0%)	
On Leave (unavailable)	31(-)	
No Role Selected		2 (2.4%)
Total Workers Available	200	83
Resident Group:		
Overall Number of Residents	225	
Legally Capable Residents (N)	51	41
Total (Resident and Staff)	251	124 (49.4% of N)

organizational structure. These groups were subsequently collapsed into five main categories that represented the individual's relationship with the organization (Table 1.1). For example, leaders represented those who have some leadership responsibility in the home; this category included recreation and rehabilitation workers and Registered Practical Nurses. Registered Nurses (RN's) were categorized as managers to represent their direct supervisory relationships with other workers. Non-direct care workers included those persons working in dietary and housekeeping departments and administrative assistants; this category was developed to reflect individuals' lesser involvement in the provision of direct care.

Age, gender and ethnicity.

The mean age of staff was 43.8 years, the mean age of resident respondents was 82.9 years (Table 1.1). When ages of individuals in the various staff groups were compared, managers were the eldest (47.0 years), followed by non-direct care workers (almost 47 years) and by direct care workers (43.7 years). Leaders were the youngest of the personnel groups (39.9 years) (Table 1.1). Not surprisingly, females dominated both the staff and the resident sample (85.5 %) with higher percentages of women in the roles at the bottom of the hierarchy: 78.6% of managers and 93.5% of direct care workers were women. Less than 14% of the total sample identified themselves as members of an ethnic minority. Among managers, 7% were of an ethnic minority, while more than 22% of direct care workers were. Direct care workers and non-direct care

workers differed slightly in terms of gender and ethnicity. Non-direct care workers had fewer women and persons of ethnically diverse backgrounds than occurred among direct care workers.

Income.

Those persons who earned less than $12,000 were typically residents who had no income apart from the Old Age Security and the Guaranteed Income Supplement. Other income differences reflected the different roles filled and the part-time nature of many positions held; almost 43% of managers earned more than $45,000 per year. These data were somewhat misleading because respondents did not always reflect only their overall annual income in this position, but rather total income including dollars which may have come from other sources. And also, those who earned a high hourly rate may have reported a lower income if they reflected the dollars earned part-time rather than the salary level. The actual hourly rates paid reflected that Registered Practical Nurses (leaders) earned $17.99; health-care aides (direct care workers) and maintenance workers each earned $16.47; dietary aides, housekeeping workers and laundry workers earned $14.70 (non-direct care workers). Salary scales of workers higher in the organization were not available. Analysis of these data was limited as a result of this ambiguity.

Education.

Residents who grew up in the early twentieth century had modest educations, for the most part, with a mean of just over 10 years. The education

Table 1.1: Demographics by Personnel Group

Variables by Group	Managers (N=14) Percentage of total in category (Means)	Leaders (N=22) Percentage (Means)	Direct Care Workers: (N=31) Percentage (Means)	Non-Direct Care Workers: (N=14) Percentage(Means)	Residents: (N=41) Percentage (Means)
Age:	-47	-39.95	-43.73	-46.93	-82.85
Gender:					
Male	21.4%	9.1%	6.5%	7.1%	17.1%
Female	78.6%	86.4%	93.5%	92.9%	82.9%
No Answer		4.5%	0.0%	0.0%	0.0%
Ethnicity:					
Minority	7.1%	4.5%	22.6%	14.3%	12.2%
Dominant	85.7%	95.5%	67.7%	85.7%	87.8%
Group	7.1%	0.0%	9.7%	0.0%	0.0%
No Answer					
Income ($ per year):	0.0%	4.5%	0.0%	0.0%	48.8%
0-12,000	7.1%	0.0%	16.1%	0.0%	36.6%
12,001-20,000	21.4%	54.5%	71.0%	71.4%	9.8%
20,001-35,000	21.4%	31.8%	3.2%	28.6%	0.0%
35,001-45,000	42.9%	0.0%	6.5%	0.0%	2.4%
Over 45,000	7.1%	9.1%	3.2%	0.0%	2.4%
No Answer					
Education (years):	-16.77	-14.43	-14.59	-13.14	-10.27
Tenure (months):	-96.31	-93.36	-118.62	-190.07	-42.44

Variables by Group	Managers (N=14) Percentage of total in category (Means)	Leaders (N=22) Percentage (Means)	Direct Care Workers: (N=31) Percentage (Means)	Non-Direct Care Workers: (N=14) Percentage(Means)	Residents: (N=41) Percentage (Means)
Unit of Work (staff)					
Age in Place	14.3%	18.2%	32.3%	21.4%	N/A
Special Care	0.0%	4.5%	25.8%	14.3%	
Variable	78.6%	68.2%	32.3%	50.0%	
No Answer	7.1%	9.1%	9.7%	14.3%	
Schedule (staff)					
Full Time	57.1%	59.1%	51.6%	92.9%	N/A
Part Time	21.4%	36.4%	41.9%	0.0%	
Variable	14.3%	0.0%	6.5%	7.1%	
No Answer	7.1%	4.5%	0.0%	0.0%	
Shift (staff)					
Days	57.1%	59.1%	29.0%	92.9%	N/A
	21.4%	27.3%	38.7%	0.0%	
Afternoons/Nights	21.4%	13.6%	32.3%	7.1%	
	0.0%	0.0%	0.0%	0.0%	
Variable					
No Answer					

levels of staff reflected in their roles in the organization with managers having more than 16 years education and non-direct care workers having just over 13 years. Direct care workers had more education than the leaders to whom they sometimes reported and more than non-direct care workers.

Tenure.

Staff had been with the organization on average more than 10 years while residents had lived in the home for about three and one half years. Managers and leaders had less tenure than both direct care and non-direct care workers. Leaders had the least tenure of all groups and non-direct care workers had the most. These latter had worked at this facility an average of fifteen to sixteen years.

Unit of work.

More than half of staff worked on several units in the home depending on the need in the unit. More respondents reported that they worked with elders who are less cognitively impaired with only 16% of the respondents overall reporting that they usually worked with residents of the special care units. Staff members higher in the hierarchy reported working less with special care residents. Direct care workers worked with special care residents more (25.8%) than did any other personnel group (Table 1.1).

Schedule and shift.

Over sixty percent of workers overall reported working full-time and more than half worked days only. Some workers reported working

part-time/full-time; when asked what this meant, they said they worked full-time hours but were paid on a part-time basis. Table 1.1 has shown the breakdown according to personnel group. Those persons higher in the organization more often worked full-time day shifts. In the case of direct care workers, though, more than 48% worked part time or variable schedules and over 71% worked afternoons, nights or variable shifts.

Descriptive Data: Scales

As discussed in the methodology section of this paper, the scales used in this questionnaire package were all variants of the SIDM (Kruzich, 1989). First, the scale (SIDM) was used as it was originally designed by Kruzich (1989). This scale was subsequently divided into its two subscales: the Care Subscale and the Organization Subscale. Also for this research four extra items were added to the Care Subscale (Care Subscale with Added Items). It was this final Care Subscale with Added Items that residents completed. The Staff Involvement in Decision Making (SIDM) scale that was altered to reflect respondents' perceptions of a superior, the SIDM-Perception of Superior, asked staff to answer the questions as the respondent believed someone at the level of their supervisor would answer the questions. This scale, called SIDM-PS from here, was also comprised of the Care Subscale-PS and the Organization Subscale-PS. These scales were used in the analysis both in their entirety and also as subscales. Staff completed both full scales. The two main scales and their four subscales, considered individually, had suitable levels of reliability

ranging from Chronbach's Alpha .8619 to a high of .9653 (Table 2.0).

Table 2.0: Reliability

Scales	Number of Items	Chronbach's Alpha
Staff Involvement in Decision Making (SIDM)	27	0.9146
Care Subscale	15	0.8671
Care Subscale with Added Items	19	0.8925
Organization Subscale	12	0.8619
SIDM: Perception of Superior (SIDM-PS)	27	0.9411
Care Subscale: Perception of Superior	15	0.9653
Organization Subscale: Perception of Superior	12	0.8849

Table 3.0 identified the mean scores on each of these scales. The two care subscales, for the individual themselves and the individual's perception of the superior, only allowed for a visual inspection of the means without comparison due to a different number of items. In the case of other scales with the same number of items, comparisons could be drawn. For example, the mean score of SIDM-PS was higher than for the SIDM scale itself; the mean of the Organization Subscale-PS was higher than the Organization Subscale itself.

The means of the scales were then divided by personnel groups (Table 3.1). Here, in the SIDM scale, the means of managers (69.09), leaders (62.56), direct care workers (54.56) and non-direct care (37.58) workers scores differed. Similarly, in the Care Subscale with Added Items, the mean scores of

Table 3.0: Descriptives of Scales

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
SIDM(r)	69	29	115	56.88	17.263
Care Subscale	107	15	67	34.59	11.839
Care/Added Items Subs	107	19	79	43.60	14.792
Organization Subscale	73	12	56	24.70	8.682
SIDM -- Perception of Superior	69	31	129	87.90	23.603
Care Subscale -- Perception of Superior	70	15	75	45.76	18.046
Organization Subscale - Perception of Superior	71	15	58	41.75	10.482
Valid N (listwise)	63				

managers (45.08), leaders (44.35), direct care workers (44.26) and non-direct care workers (21.23) differed. In this Care Subscale with Added Items, the mean of residents' scores (49.85) was in response to questions answered by residents that had been modified to reflect not their own decisions, but those made about them by others. The mean scores on the Organizational Subscale, also differed between managers (35.08), leaders (25.59), direct care workers (21.62) and non-direct care workers (20.38). When the SIDM-PS scale was reviewed after being divided by group, the mean scores of direct care workers (96.92) and the non-direct care workers (63.73) were the most diverse. In the

Table 3.1: Descriptives Scales by Groups

Scales	Managers Mean (SD)	Leaders Mean (SD)	Direct Care Workers Mean (SD)	Non-Direct Care Workers Mean (SD)	Residents Mean (SD)
SIDM (r)	69.09 (13.179)	62.56 (11.894)	54.56 (14.590)	37.58 (6.598)	
Care Added Items Subscale	45.08 (13.022)	44.35 (8.336)	44.26 (14.960)	21.23 (2.522)	49.85 (12.964)
Organization Subscale	35.08 (12.937)	25.59 (6.226)	21.62 (5.067)	20.38 (5.650)	
SIDM PS	90.17 (24.154)	89.50 (19.546)	96.92 (21.810)	63.73 (15.793)	
Care Subscale PS	46.08 (16.779)	48.39 (14.613)	55.65 (13.966)	21.00 (7.224)	
Organization Subscale-PS	44.85 (9.694)	41.11(9.615)	41.43 (10.668)	42.18 (10.815)	

Care Subscale-PS, the mean scores of direct care workers (55.65) also differed more from non-direct care workers (21.00) than from other groups. However, in the Organizational Subscale, the scores were similar in the groups.

Descriptive Data: Other Variables

Other questions were posed that used Likert type scales where respondents demonstrated how many and how important their decisions were in regard to residents, staff and self. Table 3.2 indicates that in general, respondents' scores reflecting their perceptions of the importance their superior placed on their decisions regarding residents, staff and themselves were higher than scores reflecting the respondents' belief about the importance of their own decisions regarding residents, staff and themselves. The same pattern applied to

Table 3.2: Descriptives of Individual Variables (all staff groups)

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
My decisions about residents: importance	65	1	5	3.38	1.085
My decisions about staff: importance	53	1	5	2.83	1.411
My decisions about self: importance	67	1	5	3.51	1.248
My influence	76	1	5	2.13	.914
How others perceive my influence	76	1	5	2.32	.983
Philosophy: my use	67	1	5	3.43	1.520
Philosophy: others' use	62	1	5	3.24	1.468
PSDecisions about residents: importance	65	1	5	4.00	.952
PSDecisions about staff: importance	68	2	5	3.93	.886
PSDecisions about self: importance	60	1	5	3.73	1.023
PSThat person's perceived influence	72	1	5	3.71	1.027
PSThat person's influence- by others	72	1	5	3.83	1.007
Valid N (listwise)	39				

their perceived overall influence. Respondents believed supervisors above them had more influence than they themselves had; and respondents also believed that supervisors held similar perceptions about the supervisors' own influence when compared with the views held by others about the supervisors' influence. Respondents felt others applied the philosophy less often than they themselves did. Overall, staff respondents felt little influence or decision importance when compared to supervisors, although they felt they followed the home's philosophy more than other workers.

Table 3.3 compares the means of these individual variables by group, or more precisely, by the described dyadic units where those units involved staff only. In most instances, the mean scores of managers were higher than those of leaders; and the mean scores of leaders were higher than those of direct care workers. All staff groups felt they used the philosophy more often than did others. Resident respondents did not use these variables. The exceptions to these patterns were in the following instances. Staff leaders felt those one level above them in the hierarchy made more important decisions about residents and staff than managers felt about those who were one level above them. Similarly, direct care workers felt people one level above them in the hierarchy made more decisions about themselves than leaders felt about the workers who were one level above them. In both of these cases, the person lower in the organizational hierarchy attributed more importance to the decisions made by supervisors than did those above them in the hierarchy. The responses of non-direct care

Table 3.3: Means (Standard Deviations) of Individual Variables by Groups

Variables	Managers	Leaders	Direct Care Workers	Non-Direct Care Workers
Decisions about Residents: importance	3.69 (.630)	3.50 (.730)	3.30 (1.063)	3.08 (1.782)
Decisions about Staff: importance	3.83 (1.115)	2.77 (1.166)	2.35 (1.367)	2.50 (1.716)
Decisions about Self: importance	4.01 (.793)	3.56 (1.149)	3.05 (1.362)	3.71 (1.383)
My influence	2.62 (1.121)	2.17 (.707)	2.00 (.947)	1.93 (.829)
How others perceive my influence	2.69 (1.032)	2.33 (.767)	2.13 (1.042)	2.36 (1.082)
Philosophy: my use	4.46 (.527)	4.06 (1.088)	2.85 (1.592)	3.00 (1.710)
Philosophy: others' use	3.89 (.928)	3.76 (.970)	3.04 (1.737)	2.46 (1.664)
PS Decisions about Residents: importance	4.00 (1.000)	4.07 (.799)	4.04 (.955)	3.92 (1.165)
PS Decisions about Staff: importance	4.00 (.913)	4.06 (.659)	3.76 (1.012)	4.08 (.900)
PS Decisions about Self: importance	3.83 (.835)	3.53 (1.068)	3.68 (1.157)	4.09 (.944)
PS That person's perceived influence	3.92 (1.038)	3.83 (.514)	3.68 (1.249)	3.58 (.793)
PS That person's influence, by others	4.23 (.927)	3.89 (.676)	3.75 (1.175)	3.75 (754)

workers did not follow these patterns. These particular workers felt they made more important decisions about self than did the direct care workers; and they also felt supervisors made more important decisions about staff and self than did any of the other staff groups. Each group of workers believed others felt they had more influence than they themselves felt they had. The scales and the individual variables were also divided by gender, ethnicity, schedule, shift and

unit (Table 3.4). A visual inspection of the mean scores of the main SIDM scale showed higher scores were achieved by those who were males, dominant ethnic group members, individuals who worked full time, individuals who worked days, and by those who cared for special care residents. However, in the Care Subscale with Added Items, the opposite was true; females, members of the minority group, those who did not work full time, those who did not work days and those who did not work in special care scored higher.

Respondents also answered questions pertaining to the number of decisions they made in each of the three decision areas. Although the data represented in Table 3.5 were badly skewed, there were findings of some interest (Table 3.5). Leaders counted fewer decisions about residents and staff than did managers; similarly, direct care workers counted fewer decisions than leaders; and non-direct care workers had the lowest mean scores in each of these two decision areas. While leaders made many more decisions about themselves than other groups, they also perceived that supervisors made many more decisions in all decision areas than did any other of the groups.

When the number of decisions in each decision area was divided by gender, ethnicity, schedule, shift and unit, females identified more decisions in each of the three decision areas than males, but members of the dominant cultural group made more decisions in each area than did those from a minority group. Full-time workers made more decisions about residents than part time, but those working days made fewer decisions about residents than those who

Table 3.4: Scales and Individual Variables by Demographics

Variable	Male Mean (StD)	Female Mean (StD)	Dom't Group Mean (StD)	Minority Group Mean (StD)	Full Time Mean (StD)	Not Full Time	Days Mean (StD)	Not Days	Age in place	Special Care
SIDM (r)	66.86 (28.621)	55.66 (15.671)	57.42 (17.212)	53.38 (19.935)	57.76 (20.075)	54.56 (12.268)	59.16 (17.440)	53.52 (17.158)	56.44 (17.633)	57.60 (17.128)
Care Added Items Subscale	40.92 (16.230)	43.97 (14.810)	42.82 (14.009)	46.92 (19.931)	40.19 (16.847)	40.46 (11.172)	40.48 (16.489)	40.61 (12.745)	47.84 (14.066)	47.18 (17.526)
SIDM - PS	81.71 (19.242)	89.90 (23.358)	90.22 (22.171)	73.75 (27.390)	85.71 (24.387)	94.04 (20.661)	87.41 (23.778)	89.81 (22.900)	91.00 (24.757)	88.70 (27.346)
Care Subscale - PS	34.00 (15.737)	47.69 (17.866)	46.10 (18.155)	42.75 (19.211)	43.23 (19.222)	51.76 (14.240)	42.55 (19.693)	50.19 (15.136)	47.53 (19.171)	49.10 (19.296)
Decisions about Residents: Importance	3.67 (.816)	3.40 (1.138)	3.46 (1.077)	3.11 (.928)	3.34 (1.237)	3.45 (.800)	3.39 (1.104)	3.44 (1.121)	3.44 (1.153)	3.55 (1.128)
Decisions about Staff: Importance	3.20 (1.483)	2.85 (1.459)	2.88 (1.452)	2.70 (1.252)	2.94 (1.556)	2.59 (1.176)	2.90 (1.470)	2.83 (1.435)	2.56 (1.424)	2.80 (1.398)
Decisions about Self: Importance	3.83 (.753)	3.48 (1.295)	3.60 (1.211)	3.20 (1.317)	3.47 (1.297)	3.64 (1.217)	3.56 (1.163)	3.50 (1.421)	3.25 (1.342)	3.70 (1.160)
My influence	3.86 (.900)	2.01 (.801)	2.13 (.914)	2.27 (1.191)	2.20 (.957)	2.04 (.962)	2.24 (.821)	2.09 (1.138)	1.88 (.697)	2.31 (.855)

Variable	Male Mean (StD)	Female Mean (StD)	Dom't Group Mean (StD)	Minority Group Mean (StD)	Full Time Mean (StD)	Not Full Time	Days Mean (StD)	Not Days	Age in place	Special Care
My influence by others	3.57 (1.272)	2.22 (.928)	2.26 (.957)	2.82 (1.250)	2.50 (.983)	2.04 (1.036)	2.43 (.914)	2.26 (1.163)	2.12 (.697)	2.77 (.927)

Table 3.5: Number of Decisions in Three Categories by Group

Variables	Managers Mean (SD)	Leaders Mean (SD)	Direct Care Workers Mean (SD)	Non-Direct Care Workers Mean (SD)
Decisions about Residents: number	30.54 (25.605)	19.88 (25.205)	8.29 (13.770)	2.36 (4.618)
Decisions about Staff: number	19.27 (17.577)	3.31 (4.586)	2.80 (9.042)	3.83 (7.685)
Decisions about Self: number	22/27 (30.594)	78.50 (247.063)	8.95 (22.772)	15.50 (17.992)
PS Decisions about Residents: number	37.30 (37.095)	108.71 (262.364)	36.89 (49.548)	32.80 (26.972)
PS Decisions about Staff: number	30.50 (29.470)	62.87 (124.364)	27.72 (45.286)	27.00 (26.397)
PS Decisions about Self: number	32.78 (30.829)	98.93 (251.387)	21.60 (23.142)	33.36 (35.012)

Table 3.6: Number of Decisions by Demographics

Variables	Female	Male	Non Dom'nt	Dom'nt	Full Time	Not Full Time	Days	Not Days	Age in Place	Not Age in Place
Decision/ residents: Number	14.54 (21.816)	10.00 (5.550)	9.38 (13.928)	14.29 (21.030)	14.83 (22.837)	10.92 (15.157)	13.31 (19.330)	15.29 (23.222)	12.20 (13.100)	15.11 (22.816)
Decision/ staff: Number	6.48 (12.393)	4.90 (5.390)	4.25 (5.339)	5.77 (10.067)	6.24 (10.127)	4.32 (8.577)	6.64 (10.558)	5.96 (13.892)	1.80 (3.932)	7.94 (13.477)
Decision/ self: Number	33.06 (136.323)	16.20 (20.241)	7.80 (12.538)	35.13 (138.747)	17.32 (25.508)	53.00 (202.999)	48.67 (165.56)	4.96 (8.678)	80.54 (276 .315)	17.68 (27.014)

Table 4.1: Number of Persons Dependent on Respondent by Group

Variable	Managers Mean (StD)	Leaders Mean (StD)	Direct Care Workers Mean (StD)	Non-Direct Care Workers Mean (StD)
Number of persons dependent on Respondent	14.42 (12.064)	21.50 (53.453)	2.46 (2.105)	21.75 (56.659)

did not work days. Those working with special care residents made more decisions about residents than did those working with "Age in Place" residents (Table 3.6).

Finally, respondents estimated the number of persons who were dependent on them for their decisions (Table 4.1). In this case, leaders and non-direct care workers identified that more people were dependent on them for decisions than did either managers or direct care workers. Direct care workers identified that only a mean of 2.46 persons were dependent on them for their decisions. Although non-direct care workers recognized the impact of their decisions on many others, direct care workers did not have a similar perception about their decisions.

Bivariate Results

Data Modifications

Tests were conducted to assure that variables used in bivariate and multivariate tests were normally distributed with homogeneous variance (Appendix F). As a result of these tests specific variables were excluded from some tests. For example, age, tenure and the two organization subscales were not normally distributed, nor were the individual variables of decision making importance, perceived influence and use of the home philosophy. Also, ethnicity and gender were omitted from some tests due to the very low number of respondents in some cells, particularly males and minority members. Six cases that were outliers were identified and removed from the data set before

proceeding with the bivariate analyses.

Differences in job duties between non-direct care workers and the rest of the respondents were also seen through qualitative comments made by non-direct care respondents when they indicated they felt different from the others. For this reason, non-direct care workers were included in enough tests to allow for some comparison with direct care workers. The Care Subscale with Added Items version of the subscale was selected for further tests in preference to the main Care Subscale in part because of its higher level of reliability and also because of the importance of the specific items added (toileting, clothing selection, food selection and personal washing, shaving etcetera) in the lives of institutionalized older adults. What follows is a summary of bivariate results including correlations and Independent T Tests.

Correlations.

Pearson (r) correlations were conducted on normally distributed variables. Similarly, Spearman (rho) correlations were run using scales with the individual decision, influence and philosophy variables, and between individual decision variables. Correlations were run, first with all respondents (rho), and then subsequently after data were divided by personnel group. Because of the large number of correlations, and because the correlation result only provide background to the main findings in the study, only significant ($p<0.01$, or 0.05) and moderate or strong correlations have been reflected in this document. While the text that follows is a summary only, more complete details of these data are

available in Appendix F (Tables F1-F7).

Correlations between scales

Pearson (r) correlations that used all the staff data indicated that scales correlated with each other, particularly when the scales were similar. That is, there was a moderate correlation between SIDM and SIDM-PS as measured by Pearson (r) Correlations ($r=.404$, $p=.01$), and a strong positive relationship between the Care Subscale with Added Items and the Care Subscale-PS ($r=.620$, $p=.01$).

Staff Involvement in Decision Making.

In addition to the SIDM scale being significantly correlated with the SIDM-PS Scale, overall scale scores correlated strongly with respondents' perception of decision importance about staff ($rho=.555$, $p=.01$), with respondents' perception of their influence ($rho=.456$, $p=.01$) and how others perceive their influence ($rho=.348$, $p<.01$). There was also a relationship between this scale and the two philosophy questions — the respondents' use of the philosophy ($rho=.453$, $p=.01$) and its use by others ($rho=.348$, $p=.01$). (Table F3). These findings have begun to establish a relationship between the various decision variables included in the study: the scales, decision importance, perceived influence and use of the home philosophy.

When considered as separate personnel groups, while managers' scores (SIDM) were not correlated with other variables, leaders', direct care workers' and non-direct care workers' SIDM scores did correlate with some or several

individual variables (Table F7). Unlike direct care workers, scores of non-direct care workers on this scale correlated with their perceived level of importance of their decisions regarding each of residents (rho=.841, p=.01), staff (rho=.912, p=.01) and self (rho=.615, p=.05). These findings demonstrate some difference between the personnel groups, and particularly between direct care and non-direct care workers.

Care with Added Items Subscale.

In addition to the significant correlation between this scale and the Care Subscale-PS, the overall staff scores on this scale related moderately to several of the individual decision variables. When Care Subscale with Added Items scores were divided by personnel roles, the scores of managers, direct care workers and non-direct care workers related to individual decision variables, but leaders' scores did not.

Staff Involvement in Decision Making-Perception of Superior.

When all staff respondents were considered together, in addition to the relationship with the SIDM scale itself, how much decision-making power superiors were perceived to have (SIDM-PS) correlated with respondents' belief about the perceived influence held by the supervisor (rho=.384, p=.01) and by others about the superiors' influence (rho=.410, p=.01).

When the scores on this scale were divided by personnel groups, more correlations emerged. While there were none indicating moderate or strong correlation for managers, leaders' scores (SIDM-PS) correlated with their view

of other decision-making variables about superiors. But the more decision-making power leaders ascribed to the superior, the less they used the philosophy (rho=-.500, $p<0.05$). Scores of direct care workers (SIDM-PS) also correlated with other decision making variables that related to the superior. Non-direct care workers were the only group whose decision-making power was linked to decision importance about residents (rho-.744, p=.05). And, the more decision-making power non-direct care workers ascribed to superiors, the less apt they were to be older workers (rho= -.714, p=.05).

Care Subscale-Perception of Superior.

When scores on this subscale were divided by personnel roles, there were no moderate or strong correlations for either managers or leaders. However, scores on this scale by direct care workers correlated with their view regarding several other variables related to the superior. Again, it was only the non-direct care workers' scores which related to the perception of the importance of their decisions about residents (rho=.604, p=.05) and when non-direct care workers ascribed more decision-making power to superiors, they tended to be younger (rho=-.601, p=.05).

Correlations With Related Individual Variables

Perceived importance of respondent decisions.

In general, when all staff respondents were considered together, the three variables reflecting perceptions of the importance of decisions about *residents*, *staff and self* correlated with each other at a significant level ($p<0.01$

or $p < 0.05$) (Table F4). When divided by groups (Table F7), the decision importance about *residents* correlated strongly with decision importance about staff where respondents were managers (rho= .793, p=.01), direct care workers (rho=.747, p=.01) or non-direct care workers (rho=.855, p=.01), but not leaders. Where respondents were direct care workers, decision importance regarding residents correlated strongly with all individual decision making variables (decision importance, perceived influence and philosophy use). In the case of non-direct care workers, decision importance about residents correlated strongly with several other decision importance variables, but not with philosophy use.

When divided by groups, managers' and direct care workers scores on the importance of decisions about *staff* correlated with decision importance in other areas and with their perception of their influence in the eyes of others. However, for leaders, there were no correlations at the moderate or strong level. In the case of non-direct care workers, decision importance about staff also correlated with decision importance variables and with the two philosophy variables.

Considered separately, managers' decision importance scores about *self* correlated only with their decision importance about staff (rho=-.695, p=.05) while leaders' scores correlated negatively with tenure (rho-.495, p=.05). However, direct care workers' and non-direct care workers' scores correlated with most decision variables, and in the case of direct care workers also with

tenure (rho=.584, p=.01).

Perceived importance of superior's decisions.

Using all staff respondents and also when data were divided by groups, perceptions of the superiors' view of the importance of decisions about *residents* correlated with other similar decision importance variables. In the case of managers, perceptions of superiors' decision importance about residents correlated negatively with managers' age (rho=-.681, p=.05). Non-direct care workers' scores regarding residents correlated strongly with the perceived influence of the supervisor as seen by others (rho=.638, p=.05), and with both philosophy variables. The perceived importance of superiors' decisions about *staff* held by direct care workers correlated strongly with their view of the superiors' decision-making importance and influence. Non-direct care workers' scores regarding their decisions related to staff correlated with the respondents' philosophy use (rho=.757, p=.01). Managers' perception of the superiors' view of the importance of their decisions about *self* negatively correlated with managers' age (rho=-.728, p=.05). Among non-direct care workers, scores related to their decisions about self positively correlated with the respondents' use of the philosophy (rho=.672, p=.05).

Perceived influence.

When scores on the two influence variables were divided by personnel roles, managers' *perceived influence* correlated negatively with their age (rho=-.610, p=.05). Both direct care workers' and non-direct care workers' influence

correlated with their decision importance regarding residents. For direct care workers, their perception of the views of others about their influence related strongly to their perceived decision importance in all three decision importance areas identified. The *perceived influence held by the superior*, for leaders, correlated with the importance ascribed by superiors to their decisions about self (rho=.574, p=.05), but negatively to the leaders' philosophy use (rho=-.573, p=.05) and their age (rho=-.588, p=.05).

Use of organizational philosophy.

When all staff respondents were considered together, use of the organizational philosophy in decision making correlated with its use by others, and with several of the other individual variables (Table F6). When divided by groups (Table F7), philosophy variables correlated with each other. Philosophy use by direct care workers (rho= .464, p=.05) and managers (rho=.791, p=.05) related to the importance they described about their decisions about residents. In the case of leaders, philosophy use by others correlated negatively with the respondents' perception of supervisors' influence (rho=-.573, p=.05). For direct care workers both philosophy variables related to their tenure with the organization. Non-direct care workers' philosophy use correlated with their perceptions of the importance of supervisors' decisions.

Overall Differences between Groups

The scores on the scales were used as dependent variables and respondents were grouped according to their role in the organization using the

hypothesized dyadic units. Data were subsequently also divided according to income level, shift, schedule and unit or work. Independent T-Tests were conducted. Since the focus of this small study was decision making by personnel groups of workers, that is, by managers/leaders, by leaders/workers, and by workers/residents, T-Tests were particularly important because of their capacity to measure differences in means for scales of the two groups of each dyadic unit. Comparing means of managers and leaders in the SIDM ($t=1.342$, $p<.192$), the Care/Added Items Subscale ($t=.185$, $p<.854$), the SIDM-PS scale ($t=.083$, $p<.934$), and finally the Care Subscale-PS ($t=-.399$, $p<.693$), there were no significant differences. Independent Sample T Tests revealed no significant difference in mean scores on any of the scales in any of the dyadic units; between managers and leaders (Table 5.1), between leaders and direct care workers (Table 5.2) and between direct care workers and residents (Table 5.3). T and p values can be found in the accompanying tables listed. In the first two dyadic units, the means on all four scales were compared; in the last dyadic unit, the mean of scores on only one scale was reported because the residents only completed the one scale, that is, the Care Subscale (Table 5.1, 5.2 and 5.3).

An exploratory Independent T-Test was also run on the means of scores on the scales for direct and non-direct care workers (Table 5.4) to confirm that the qualitative difference evident in job descriptions held in these scales. In each of the SIDM ($t= 3.837$, $p<.0005$), the Care with Added Items Subscale

Table 5.1: Dyadic Unit I (T Tests-Managers and Leaders)

Independent Samples Test: Dyad I. Managers/Leaders

		Levene's Test for Equality of Variances		t-test for Equality of Means			
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference
SIDM(r)	Equal variances assumed	.460	.504	1.342	25	.192	6.53
Care/Added Items Subscale	Equal variances assumed	3.806	.061	.185	28	.854	.72
SIDM -- Perception o Superior	Equal variances assumed	.814	.375	.083	28	.934	.67
Care Subscale -- Perception of Superio	Equal variances assumed	.287	.596	-.399	28	.693	-2.31

Table 5.2: Dyadic Unit II (T Tests–Leaders and Direct Care Workers)

Independent Samples Test: Dyad II. Leaders/Direct Care Workers

		Levene's Test for Equality of Variances		t-test for Equality of Means			
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference
SIDM(r)	Equal variance assumed	3.370	.074	1.857	41	.070	8.01
Care/Added Items Subscale	Equal variance assumed	11.122	.002	.024	42	.981	.09
	Equal variance not assumed			.027	41.547	.979	.09
SIDM -- Perception o Superior	Equal variance assumed	.827	.368	-1.157	42	.254	-7.42
Care Subscale -- Perception of Superi	Equal variance assumed	.063	.804	-1.665	42	.103	-7.26

Table 5.3: Dyadic Unit III (T Tests-Direct Care Workers and Residents)

Independent Samples Test: Dyad III. Direct Care Workers/Residents

		Levene's Test for Equality of Variances		t-test for Equality of Means			
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference
Care/Added Items Subscale	Equal variances assumed	1.827	.182	-1.563	59	.123	-5.59

Table 5.4: Direct Care Workers and Non-Direct Care Workers (T Tests)

Independent Samples Test: Direct Care Workers/Non Direct Care Workers

		Levene's Test for Equality of Variances		t-test for Equality of Means			
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference
SIDM(r)	Equal variances assumed	15.413	.000	3.837	37	.000	16.97
	Equal variances not assumed			5.002	36.944	.000	16.97
Care/Added Items Subscale	Equal variances assumed	29.889	.000	5.477	38	.000	23.03
	Equal variances not assumed			7.772	28.941	.000	23.03
SIDM -- Perception of Superior	Equal variances assumed	3.220	.081	4.552	35	.000	33.20
	Equal variances not assumed			5.186	25.902	.000	33.20
Care Subscale -- Perception of Superior	Equal variances assumed	5.374	.026	8.070	36	.000	34.65
	Equal variances not assumed			10.067	35.371	.000	34.65

($t=5.477$, $p<.0005$), the Care Subscale–PS ($t=8.070$, $p<.0005$) and the SIDM–PS ($t=5.186$, $p<.0005$), the difference identified is significant. Non-direct care workers were excluded from subsequent tests.

There were no significant differences in the mean scores on the scales when the staff respondents were split according to their unit of work, schedule or shift. However, when staff data were split according to income, there were significant differences in the mean scores where those making over $45,000 were considered, but only for the original scale, SIDM. There were no significant differences in means between other staff income groups.

Multivariate Results

Multiple regressions on each of the four scales revealed a consistent link between the respondent's perception of their own decision–making power and their perception of the decision–making power held by their superior. With some scales, one or two other single variables also presented in the regression models that resulted, but without consistency between dependent variable scales. These results have been detailed below for each scale.

Variations in the scores of staff respondents on the Staff Involvement in Decision Making (SIDM) were explained by a model (Table 6.0) which included the SIDM–PS, whether the respondent was a worker or not and the degree of importance respondents placed on their decisions about staff. This model explained 43.5% of the variance in the scores on SIDM. The most influential variables ($p<0.005$ and $p<0.006$) in explaining the variance were the SIDM–PS scale and the respondents' perception of the importance of their

decisions about staff, but the scale was the more robust variable of the two in this prediction because it consisted of multiple items. For each one point increase in the decision-making score the respondent ascribed to the person at the level of their superior, their perception of their own decision-making power increased by .248. Direct care workers scored 9.551 points less on the scale than those who were not direct care workers.

In a similar way, variance in scores on the Care Subscale with Added Items was explained by a model that included the Care Subscale-PS and the respondent's use of the philosophy (Table 6.1). This model explained 48.1% of the variance in the scores on the Care Subscale with Added Items. The most influential variable ($p < 0.0001$) in explaining the difference in the scores on this scale was the Care Subscale- PS. The respondents' use of the philosophy was also a significant factor ($p < .0.001$) but as a single item was not as robust. For each one point increase in the respondent's perception of decision-making power held by their supervisor on issues of care, their perception of their own decision-making power regarding care increased by .518.

The other two scales related to the respondents' perception of decision-making power held by those at the level of their superior. Variations in scores in the SIDM - PS scale were explained by the model which included scores on the SIDM scale, whether the respondent was a worker or not and their impression of the superiors' view of their level of influence as perceived by others (Table 6.2). This model explained 40.1% of the variance in the

Table 6.0: Staff Involvement in Decision Making

Coefficients: Multiple Regression

		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
b	(Constant)	26.892	7.578		3.549	.001
	SIDM -- Perception of Superior	.248	.083	.371	2.976	.005
	worker or not	-9.551	4.069	-.304	-2.348	.024
	My decisions about staff: importance	4.261	1.470	.379	2.899	.006

a. Dependent Variable: SIDM

b. Adjusted R Squared value for this model is .435.

Table 6.1: Care Subscale with Added Items

Coefficients: Multiple Regression[a]

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)[b]	5.529	4.940		1.119	.268
Care Subscale -- Perception of Superior	.518	.075	.648	6.943	.000
Philosophy: my use	3.237	.892	.338	3.627	.001

a. Dependent Variable: Care/Added Items Subscale

b. Adjusted R Squared value for this model is .481

scores in the SIDM-PS scale. The most influential variable ($p < 0.0001$) in explaining the variance in scale scores was the other scale SIDM. Whether the person was a worker or not ($p < .001$) and the respondents' view of the superior's perceived influence by others ($p < .001$) were also significant variables in the model. For each point increase in the respondent's perceived decision-making power, their perception of the same power held by their superior increased by .707. When the respondents were direct care workers they scored 18.797 points higher than others in their perceptions of the decision-making power held by someone at the level of their superior.

In a similar way, variances in scores on the Care Subscale-PS were explained by a model that included the Care Subscale and whether the respondent was a worker or not (Table 6.3). This model explained 44.0% of the variance in the scores in the Care Subscale-PS scale. The most influential variable in explaining the variance in the scores on this scale was the Care with Added Items Subscale ($p < .0.0001$). Respondent's perceptions of the decision-making power held by superiors in regard to care increased by .781 for each point increased in their perception of their own decision-making power regarding care. Direct care workers scored 10.187 points higher than others in assessing the care decision-making power held by someone at the level of their supervisor.

Individual variables were somewhat involved in the models as well, but the involvement was limited by the fact that they were not normally distributed

Table 6.2: Staff Involvement in Decision Making– Perception of Superior

Coefficients: Multiple Regression

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
3	(Constant)	2.416	13.953		.173	.863
	SIDM	.707	.173	.473	4.081	.000
	worker or not	18.797	5.394	.400	3.485	.001
	PSThat person's influence- by other	9.499	2.558	.404	3.713	.001

a. Dependent Variable: SIDM -- Perception of Superior

b. Adjusted R Squared value for this model is .401

Table 6.3: Care Subscale–Perception of Superior

Coefficients: Multiple Regression[a]

		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
[b]	(Constant)	9.196	6.076		1.514	.137
	Care/Added Items Subscale	.781	.136	.625	5.724	.000
	worker or not	10.187	3.934	.283	2.590	.013

a. Dependent Variable: Care Subscale -- Perception of Superior

b. Adjusted R Squared value for this model is .440.

and consisted of one item only. Nevertheless, respondent's perception of the importance of their decisions about staff, their use of the home philosophy and their assessment of how the superior sees others' perception of their own influence were at least somewhat relevant factors, but only in consideration of the main decision-making scales. This did not hold in the care subscales. The multiple regressions were not run where data were divided by personnel groups because of the small *n* in most groups. This would be a useful comparator in future studies using larger populations.

VI: Qualitative Results

Theme Development

Qualitative data were gathered in three forms: 1) direct participant comments, 2) observation and 3) follow up interviews with key personnel. This qualitative analysis has followed each of these sources in the order that they occurred in the process.

Direct Participant Comments

The staff questionnaire package asked several open-ended questions that gave respondents an opportunity to comment on previous questions asked. For example, simple comments such as "Please elaborate." and "Can you give a few examples?" gave individuals an opening for other responses. These comments were all recorded and coded. Several themes emerged and have been reflected through resident (R) and staff (S) comments, underlined below.

General decision-making themes.

Several participants commented generally about decision making itself both positively and negatively, although there were more negative comments than positive. Some of those comments about decision making included:

R.: The decisions are only made for people who cannot make them themselves. That's not me.

S.: Residents have their say as well, and some can make their own choices too!

S.: We have a lot of say about if we show up or not...

S.: We do not make decisions concerning anybody.

Both staff and residents discussed the value they placed on independence and their comments were represented by the following comments.

R.: I will make my own decisions as long as I can - right or wrong.

R.: This is not my kind of living because I am independent. The nurses get a little peeved - I pretty much get my own way - do as I please but being sensible about it.

S.: ...quality of life, I encourage independence, and respect resident choices.

S.: Higher levels of decision making would improve if more staff became involved in the process instead of the 'I don't want to be involved' attitude.

Most participants revealed frustration when they commented on decisions being made by others rather than by themselves. Comments that revealed that frustration follow:

R.: I was influenced a little but I pretended it was my idea. There was a little pushing going on.

R.: When you want to make an appointment with a dentist, you have to go through the head nurses, or when you need pills. I have a chiropractor appointment this afternoon, but I did not tell them.

S.: I think health-care aides, PSW's (Personal Support Worker) and

RPN's (Registered Practical Nurse) should have the say. We work with them (residents) all the time.

S.: Some staff will only give a resident a shower even if they ask for a tub bath, don't give them a choice of bed time, stating to the resident it has to be now because I won't have time later.

On the other hand, some participants commented about their decision-making opportunities, indicating some enthusiasm as demonstrated below.

S.: I try to make all decisions with a resident focus seeking to give them their choice where ever possible.

S.: I always put the resident's well-being first. I try to get staff to make decisions for themselves and intervene only if they don't achieve a satisfactory result.

R.: We have a meeting once a month and we tell what food we like and don't like.

When participants commented about the decisions made by those persons above them in the hierarchy, their comments tended to be critical. Staff commented particularly about decisions made by management, while residents commented about decisions made by direct caregivers.

R.: I take whatever they bring. It isn't always what I like so I don't eat very much... Snack decisions depend on if you are diabetic, the staff decide...We don't have much of a choice.

R.: Too much is left up to the nurses. I don't care how long they

have been a nurse, I know my body better than they do. They think I am just talking to be smart. I am not. When (during illness outbreak) nurses go to other floors where people are sick, they do not wear gloves. But patients can't go to other floors.

S.: I am health-care aide, not Director of Care.

S.: Management does the decision making. We do not have choices as staff.

Both residents and staff commented about routine, and its influence on their decision making.

S.: Routines are set up by management. They (managers) have no idea of the time it takes to do our duties.

S.: Everything is so routinely done that things become automatic.

S.: My daily routine schedule is written out. What I do, and when I do it.

S.: Work is very routine – only change is a new resident, illness or death of resident, the rest is routine.

R.: I don't think they have time to plan it out. They do it mechanically. I was a nurse.

R.: You have to obey the rules.

R.: They decide routine, they have to have breaks, they have their routines and we have to fit in somehow. They have to have a routine – and some residents have to wait.

Most participants who commented indicated the importance of personal choice about a variety of things.

S.: Overall most people in the home try to make resident centred decisions and to offer choice.

R.: I like to decide for myself when I go to the toilet. They say 'you can't go now – you have to wait.'

Overall, the words of participants were somewhat polarized with some asserting support for the motivation of a caring compassionate staff, while others remarked with hostility about a restrictive non-autonomous existence.

R.: If they have a good heart, they say 'I will finish you anyway before my break'.

R.: The way they restrict the residents it is like a prison – it is not a home... It is a clean place, the administrators are nice people, but the staff working with people are not encouraging (residents) to want to stay here. They are not nice. They have heavy duty to do.

S.: On many occasions I feel as though I have to do all the thinking for those working with me. At times I wonder if other workers do not have eyes and ears and common sense.

S.: I value and have respect for the unique individuality of others, staff, residents and families. I facilitate decision making and care planning... that is in the forefront of my mind.

Concerns expressed only by residents.

There were several areas of specific concern to residents about their ability, or lack of ability to make decisions about food choices, influence medical care, make decisions about bathing and access activities. The question that elicited the most comment was "In general, how much say do you have about your food selection?". Several individuals commented on the willingness of the home to listen to feedback, pointing out that there was a meeting planned where residents could give staff information about their concerns about their food.

R.: They give me skim milk all the time and I like 2%. I have diabetes and I know that myself. It (blood sugar level) hasn't been up at a danger point. I watch it without them telling me.

R.: They have the right food but it is not cooked right... I understand the reasons but don't enjoy it.

R.: They always have to smell the drink — that is not sanitary. The ones that do the kitchen, they are always changing. They work in the dark. I told them they would get into a lot of trouble with the inspector.

R.: The students get first choice of the cookies when they open a package. But we are paying the money. But I can go to the fridge whenever I want and have other things.

The other area of major concern related to decisions was expressed in

response to "In general, how much say do you have in how often you have a shower or a tub bath?" While many residents identified that they understood the rationale behind the decision that residents would have only one bath or shower per week, many expressed dissatisfaction with that decision. Participants stated their preference to have more personal choice about whether, when, and how often they had a bath or shower.

R.: Shower or bath is once a week – take it or leave it. You have to be there... They have their schedule too – they want to have breaks and this and that. If you are not there, or in bed already – they write 'refused'.

R.: I would like to have my shower early Thursday AM so I can go to mass. At first they didn't change it, but now it is right.

R.: I would like to have a tub bath – it is good for my arthritis – but it is often not working.

Participants also identified areas related to their daily care that were impacted by decisions made by others.

R.: They make me use the bedpan. You don't have the freedom, you can't always go! I don't see why they have to put us on the bed pans.

R.: The dietitian tries to give us what we like.

R.: Sometimes they do not cover me up. I am not taking my clothes off (to get care) if you are going to leave (on your break)

before we are done.

Respondents also identified medication decisions and the choice of personal physician as problematic for them.

R.: I am not notified... I know they are busy but they (doctors) would not have a practice without patients.

R.: The nurse did not agree that I was upset about the doctor changing my pills. I used to go to (women) doctors and they understood and explained how my system worked for me. This guy said - why did I come here to live? How long did I think I would live? Stupid. (Identified health problem) He didn't do anything about it.

R.: The doctor has the whole home here and that's all he should see. The home should be enough. He is not available. I was told I can't have my own doctor. When you have your own doctor for so many years and have to change to a stranger, it is not very good.

Residents expressed disappointment when they were unable to get to activities they had previously enjoyed.

R.: Sometimes they get me ready but when I get to mass it is over.

R.: We used to have all kinds of activities but it is all gone. Government cut backs.

R.: They have more say than I thought they would have. Sometimes I am in the middle of a program (TV) and they turn it off and I have to go to bed.

Residents revealed an array of perceptions related to the decision processes at the home, but the most prevailing overarching theme that they spoke of was insufficient staff levels and cutbacks.

R.: We used to get snacks regular at night, but they are having trouble with help and so some nights we don't get it. People on call just don't come without overtime pay. I had a run in with the manager about it. Two hours after I talked to (administrator) they came around with drinks at night. They left me pills with no drink... At three AM I can go and get a coffee.

R.: I would like a shower a couple of times a week, but their staff is getting smaller and smaller all the time.

R.: I can't see why there can't be someone on duty all the time. What happens in the case of an emergency. I wait 15-20 minutes, they are short of help.

R.: The government (makes the decisions). They have made all these stupid decisions on my money. Not right.

R.: The government cut a way back. I don't think it is fair. They should put residents first....

Concerns expressed only by staff.

There were several themes identified by staff including their lack of autonomy, their concern for resident well being, and sometimes their lack of respect for co-workers. Many staff wrote passionately about their commitment to a respectful, resident-centred environment,

S.: Residents' concerns are always number one.

S.: Resident focused care ... making it right for the resident even if it's 'not my job'

S.: Respect and dignity for all should be a way of life.

S.: ...recognition of residents' rights.

and some wrote with similar passion about their co-workers who were disrespectful of other individuals.

S.: The union has the most influence, especially for getting job re-instated ... even when warranted ...abuse of resident. In my department, I can only document if there are concerns that may or may not lead to dismissal.

S.: Some staff are not team players, cannot work with their peers 'their way or no way'.

Some staff identified that other team members, for example, those on other shifts, make more decisions than they themselves make. Others pointed to the concept of team as a valuable part of what they do.

S.: I work midnights... so day shift has more say.

S.: My work is shared with a co-worker, so we decide between us who does what each day.

Perhaps the most powerful words came in response to "What words come to mind when you think about decisions you make on the job?" staff participants revealed a wide variety of responses, mostly negative, including...

S.: Critically, disputed, unsupportive, challenged.

S.: Stressful, nervous, guarded

S.: individualized, objective, resident focused, assessment based, compassionate, team.

S.: consultative, problem solving, resident.

S.: Sometimes satisfied, relieved, made another enemy.

S.: Nobody cares.

Many respondents were reluctant to share information, fearing reprisal. Staff participants often refused to participate because they did not want to sign their name to the informed consent; some said that the research would be used against them. Some residents spoke in a similar manner, unable to believe that things might change.

R.: This is a whole lot of nonsense. The money should go to care.

R.: I don't want to get anyone in trouble.

R.: There are words of comfort, but I don't see anything happening. It takes weeks. It is like I am forgotten.

R.: I have made 1 or 2 suggestions to the staff and they take it from there, or at least pretend to take it from there.

R.: They have a forum that we can voice our opinion if we want. I don't know how much good it does.

Observation

The observation phase of the research had two outcomes, one that resembled the quantitative data and the other that identified themes that arose from observation. Both have been reported here in narrative form and later in Table 7.0.

Counted Observations

The initial preparatory visit to the observation unit allowed for the development of the Observation Schedule of Decision-Making Behaviours; this tool, which is reflected in Table 7, gave the structure for the subsequent counting of observed decision behaviours on the part of individuals in the observation area. Decision behaviours were selected from those observed decisions that occurred during the initial observation visit. The Observation Schedule reflected behaviours that required some decision on the part of the resident. The decisions identified for observation included the decision to stay or move to a different location, to participate in formal home activities or not, to interact with another person or not, about where to sit, to help staff or not, to participate in personal activities or gestures (sing, dance, fold), to go to the toilet or not, to go to bed or not, to eat or not, to select particular food or drink

or not, and finally the decision to accept care or not. Four subsequent observation visits to the unit occurred. On one occasion, a co-rater accompanied the observer to assure inter-rater reliability.

The number of participants in the observation area at any one time varied from five to eleven individuals, many of whom entered or left the area more than once during one observation period. Among the 220 decision behaviours that occurred, almost half were decisions to move to a different location or to simply walk, the decision to interact with another person and the decision to participate in personal activities such as folding, singing, etcetera. In these three decision areas, residents themselves had much of the decision-making influence (Table 7.0). A smaller number of decisions were made regarding participation in home activities, helping staff and changing clothing; residents had variable decision-making influence in these decisions. A very limited number of decisions were made regarding toileting and care acceptance or rejection; and in these two cases, decisions were not made by the residents. Overall, 154 decision behaviours were observed that were under the control of residents; in 47 decisions residents had influence ranging from quite a bit of influence to little influence; and 19 were decisions where the residents had no influence.

Observed Themes

The qualitative theme data that were collected simultaneously, that is, the notes taken pertaining to the observation visits, are reported here. The

methodology for coding and identifying themes within the observation data came from grounded theory (Glaser & Strauss, 1967). Themes are underlined for ease of identification.

While the types of behaviours repeated themselves through multiple observation visits, the degree of activity, the number of changes and the number of persons in the public area differed. This may have been due to the time of day, the occurrence of other home activities or friends visiting. Observations were terminated when it seemed clear that each visit yielded similar behaviours and patterns. There were two instances where residents whose proxy decision maker had not agreed to participation entered the observation area. When those individuals entered the area, the observer left. What follows is a reflection of the patterns and themes that emerged during this observation phase of the study.

Several patterns were noticed during these four observation visits. The first and most prevalent observation was walking, changing location and continuous movement of residents. This movement occurred in both solitary and partnered activity; some residents walked together, at times hand in hand, through the halls and into and out of the observation area. While residents walked, those in wheelchairs sometimes wheeled themselves or were propelled by others; most participants were on the move in whatever manner was feasible for them. Participants moved around the area, into the halls, and back to their rooms and around the halls in a repetitive manner, shuffling along, undisturbed for the most part.

Table 7.0: Decision Behaviours Observed: Degree of Resident Influence

Decision Behaviours	great deal influence	quite a bit influence	some influence	little influence	no influence	Total
Decide to change locations	69	2	4	7	5	87
To Participate in home activity/not	4			3		7
Initiate Interaction with other person/not	29	1	3	4	3	40
Decide where to sit/not	10					10
Decide to help staff/not	2					2
Decide to participate in personal activity	18			2	1	21
Decide to go to toilet/not					1	1
Decide to change clothing/not		1	1	1		3
Decide to go to bed/room/not	3	2			2	7
Decide to eat/not	7	7	1	5	3	23
Decide which food to eat/not	12	1	1	1	3	18
Decide to accept care/not					1	1
Total	154	14	10	23	19	220

In some cases, movement of those in wheelchairs was totally controlled by others if, for example, a non resident came behind a wheelchair and just began to push the resident, sometimes without the resident's awareness of even the existence of the other person behind their chair. In a few cases, a staff

member was involved in the decision to relocate, either in a friendly helpful manner by taking the resident's arm and making a suggestion, or otherwise, by pulling a resident by the hand. On some occasions, residents appeared reluctant to comply but eventually most did. At other times, when there were not staff present, residents could be seen attempting to gain access through the locked door to the adjoining unit, or in one case, a resident walked into the room of another resident. He was escorted out of the room by someone who appeared to be visiting the resident in the room.

Other observed behaviours related to eating, either at mealtime or during the mid afternoon snack time. For the most part, residents passively waited for staff to serve the food to them, and then, when served, they ate. Some staff distributed food in a pleasant manner, questioning 'Would you like apple juice or orange juice?", and received a response in one case, "With pleasure". On the other hand, two staff persons were observed distributing the drinks in a methodical manner, with neither comment nor eye contact. In one case, the staff person moaned while distributing the drinks to the residents; soon after the moan a resident threw her cup on the floor.

Staff often prompted residents to eat, or, in some cases fed someone who, although seemingly able to feed herself, did not do so. Several residents seemed to eat very little. On leaving the dining room where she did not eat, one particular resident encountered a staff person who asked if she had eaten, reminding her, "They are in there now". The resident replied "Thank you. I

can manage." In another instance a staff person, seeing that a resident had not eaten much, hurriedly fed her a few mouthfuls and then took the resident out of the dining area and back to her room. When residents turned down food at snack time the refusal was accepted by staff for the most part; on other occasions, residents took and ate the food in a seemingly dutiful manner. Interestingly, after the snack cart had been brought to the public area, while staff were absent, two residents reached down to the second shelf of the cart and helped themselves to an apple, a banana and two cookies. Subsequently, the staff took the food away from the residents and after peeling the banana, returned it to the resident. The cookies had already been eaten by the time the staff person appeared, and the apple was not returned to the resident. During a time that was not meal or snack time, a resident requested a cookie and was told "later maybe".

Decisions made in other areas were also observed. For example, where residents interacted with each other, there were few decision points, other than simply to interact with one another. On one occasion a resident asked another to take her hand off her wheelchair stating "That was a dirty trick". Another resident told her peer "Oh, shut up". Residents often fell asleep in a chair, and for the most part, were permitted to remain asleep; twice residents were wakened by staff, and once by a visitor. In one such instance, the worker wakened the resident, taking her by the hand to the activity room saying "Come on, come on, come on," in a somewhat impatient tone.

Other observed decision behaviours should be noted. For example, in two instances residents decided to lie on the floor and sleep; they were left undisturbed for a period of time, and then were roused and encouraged to move to a chair. One individual was observed crawling on the floor saying, "I'll give up on it," before returning to the sofa. When therapeutic pets visited the public area, a resident followed the pet down the hall, but was unable to catch up to the pet. Staff attempted to ensure that residents had access to the pets as they wished.

When staff gave clear direction, residents usually complied. For example, a female resident was led to a sofa, where a man was already seated. The staff directed the resident to sit there. When the resident did not, looking somewhat hesitant, the staff person said "sit down" in an authoritative tone. The resident complied. In another case where the same man was seated at the end of the sofa and a woman sat at the other end, a second woman crowded herself in between the woman already on the sofa and the sofa arm – a very small space. She soon moved to a different chair. When a resident offered a very loud rendition of "Oh Canada", staff and residents alike joined in the decision and sang. At one point, where the staff person said "we are going to the toilet, ok?" the resident complied.

Residents were responded to with both aggression and passivity. A particularly aggressive action occurred as a staff person almost dragged a resident out of the dining room, taking both of her hands and pulling and then

putting her other arm behind the resident and pushing. The resident cried out loud. The staff person said, "Do you want to sit over here? You have to sit over here. I will go and get your baby for you." This particular resident had been observed on several previous instances carrying a baby doll with her. Although the observer was in the area for an additional hour, the 'baby' was not brought to the resident during that time. Yet, in other instances, resident requests or even their mere presence received no response whatever. When a resident asked a staff person for help in placing a phone call, she received no response. In several circumstances, staff walked through the observation area without a word or a look. The cat did the same.

Those who were mobile seemed to take the opportunity to choose, whereas those who were less mobile, also seemed to be more passive. When residents interacted with staff, staff generally controlled the decision, but when they interacted with other residents, residents controlled the decision. There was an appearance of social propriety in most circumstances.

Follow Up Interviews

During data collection two questions were identified that required clarification. First, two staff persons identified that direct care workers sometimes moved into non-direct care worker roles. I wondered how often this occurred and why. Secondly, I thought that some additional qualitative data about perceptions of organizational leaders about their own decision making might assist me in discussion of the research results. In attempting to gain

clarification, I interviewed three organization leaders following the collection and analysis of other data: these included the Administrator, the Director of Care and the Social Worker. Notes were taken during the interviews. There were two main areas of inquiry during these interviews: who is the decision maker in, and, in regard to the home and why is it that staff move from direct care positions to non-direct care positions, or do they?

Who Makes the Decisions?

The interviews revealed that even these leaders did not feel they had enough decision-making influence, for the most part. Legislation, policies, funding issues and politics were identified as the main impediments to their desired decision-making influence. The Administrators at the home itself, the regional government, together with Ministry of Health compliance and documentation standards, were identified as the major sources of decisions regarding the home by all three.

Standards and guidelines from the levels of government were not seen as negotiable. For example, where documentation was not complete enough in regard to the precise level of required care for each resident, the home would not be funded at the level of dollars required to provide the level of care needed by the residents of this particular home. This documentation was described as excessive and time consuming in a setting where staff preferred to give the needed hands on care to documenting that care. Informants (A, B & C) felt decisions were made at a higher level, with unreasonable time frames imposed

(Informant B), and they stated that their own supervisors had similar restraints controlling their own decision influence (A, B & C). One of the informants felt they had enough decision authority (Informant A), though they acknowledged that the influence came as a result of working between the hierarchical layers, rather than within those layers.

Interviewees described how the regional government and the provincial Ministry of Health influenced the system. Decisions flowed down from the Ministry to the regional government, and then to nursing managers toward front line staff where nurse managers made most decisions about organization of routine, times of meals and who did what. Informants said that regardless of any decisions they made, at the end of the day, they had to prioritize (Informants A & B). One informant (B) indicated that the home felt out of control to them, in terms of their own decision-making influence; and they said that they believed front line staff shared their views.

It was identified that turf issues did exist as workers on a particular unit were protective of the unit, seeing it as a well-oiled machine that would fall apart if anything changed, such as might occur as a result of someone's decision elsewhere. Staff and residents were described as opposed to change, for the most part. For example, where other homes may have embraced the new Eden Alternative form of institutional care that incorporates animals, plants and other life assets into long-term care, this particular home has resisted that change. The reason suggested for the resistance to change was that workers may have

feared that the extra work associated with change would be put onto them. Informants (A, B & C) also stated clearly that underneath the rhetoric, staff did care about residents, but that the lack of adequate resources augmented by demands for minimalist levels of service, had created a system where workers made few decisions, if any.

Interviewees confirmed that staff and residents had little decision-making influence or control. Managers were described as not always as aware of the realities of the front line workers as they should have been. The size of the home meant there had not been as much latitude possible for internal decision making. "Very very basic needs are getting met, barely; staff are burned out; staff are getting injured because they are tired; the quality of life has decreased; and residents are left in bed." (Informant A). All informants reported that the bottom line was that residents were the ones that suffered in the end, and that this has not been an atmosphere that tolerated as many independent decisions as might have been ideal.

Transfers from Direct Care to Non-Direct Care

Interviewees confirmed that workers often did move out of direct care into non-direct care positions. This was seen as the way whereby workers managed their stress: moving to a less demanding role, with only a modest change in income. Lower levels of funding for direct care workers and continuous funding cuts had been occurring alongside the escalating resident care demands that had arisen from increasing levels of impairment. Persons

who were previously direct care workers had moved to maintenance, housekeeping, kitchen and rehabilitation departments. Such moves allowed workers a schedule with more weekend and evening time for their families. Non-direct care workers had not been required to adhere to care plans or do the manual lifts of patients that had been dangerous to both staff and residents. The fundamental reason for such changed roles was the pressure on direct care workers to meet both resident need and compliance requirements. One interviewee (B) pointed out that the greatest pressure had been on nursing staff (direct care workers), particularly when they were working short staffed. Where a non-direct care worker had been able to decide not to mop a floor, the direct care provider would still be required to change the patient, whether or not they were short staffed.

Interviewees explained that non-direct care workers were somewhat of a separate entity, often having lunch together, with little intermingling between non-direct care and direct care staff. When a non-direct care worker revealed to one of the persons interviewed that they could not go behind the desk where the nurses were, the question arose of whether there had been a lack of respect by nurses for non-direct care workers. Those part-time direct care workers who had often worked all three shifts and two jobs in order to earn a sufficient income were lower in the hierarchy than full-time permanent workers. The hours involved in such overwork may not have allowed them to manage their families. A move to another, non care, department was one strategy available

to them to get a break from the stress and from death. Here they could feel a small measure of control.

VII: Discussion

This chapter will elaborate on both the quantitative and qualitative findings of this modest study under three categories: the hypothesis, and the application of both organizational power and chaos theory. Following a description of the findings relative to the theoretical constructs initially suggested, implications for social work practice and ethical principles, and the limitations of the study will be identified.

Dyadic Units of the Hypothesis

As the discussion returns to the initial fractal-like diagram that represented the initial hypothesis (Figure 2), this analysis will use similar diagrams to reflect the three specific focus relationships between groups. Each relationship will be considered separately and then followed by a synthesis of the results.

Individual Dyadic Units

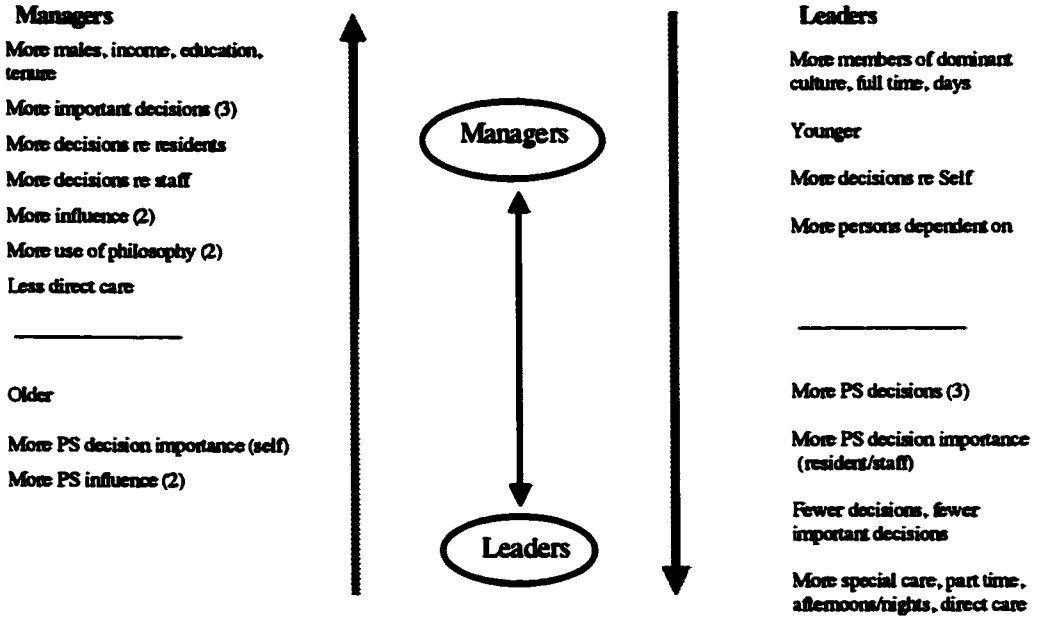
Multiple dynamics and differentials in decision-making power exist in the relationships of managers and leaders, leaders and direct care workers and most importantly, direct care workers and residents. Descriptive and demographic trends and differences between the personnel groups are plotted at the poles of each dyadic unit as a visual demonstration of decision-making dynamics and power. Each trend or characteristic is placed on the side of the diagram representing the personnel group which achieved the higher decision score, or had characteristics theorists identify with power (Mills & Simmons,

1999; Ferguson, 1984; Fagenson, 1993). Where there was more than one variable, such as in the case of decision importance (resident, staff and self), the number in brackets that follows the variable name indicates the number of individual items that followed the trend identified. Arrows represent increasing or diminishing decision-making and hierarchical power as one moves from one pole of the dyadic unit to the other pole. Items are placed above the horizontal line to demark the characteristics that denote power from those placed below the line which circumvent power. For example, making more important decisions is an indication of increased power and is therefore placed above the horizontal line. Clarification is provided in the text where necessary.

Managers and leaders.

Power differentials do exist in the relationship between managers and leaders (Figure 3). In this particular relationship, correlations revealed that age is a factor. As managers age, their perceived influence declines. Similarly, as leaders age, their perception of the superiors' influence also declined. Although Connor (1992) found that decision making varied more at lower levels, Smith, Discenza & Saxberg (1978) found decision making limited at all levels. Furthermore, West and Fenstermaker (1995) clarify that when we look at gender, and particularly the upheld values of nurturing and care giving, we can see the production of inequality. In this setting, both managers and leaders are women, for the most part. While leaders have less decision-making power than managers, both have relatively little power.

Figure 3: Decision Power Dyadic Unit I



While managers used the philosophy more often than leaders, both believed they used it more than others. This philosophy, posted at several locations through the home, has three main statements. Team work and loyalty are identified as the first principle. The second principle begins with the value of each individual, and proceeds to discuss dignity, respect and compassion, customer needs and the pursuit of excellence. Finally, the third principle sums

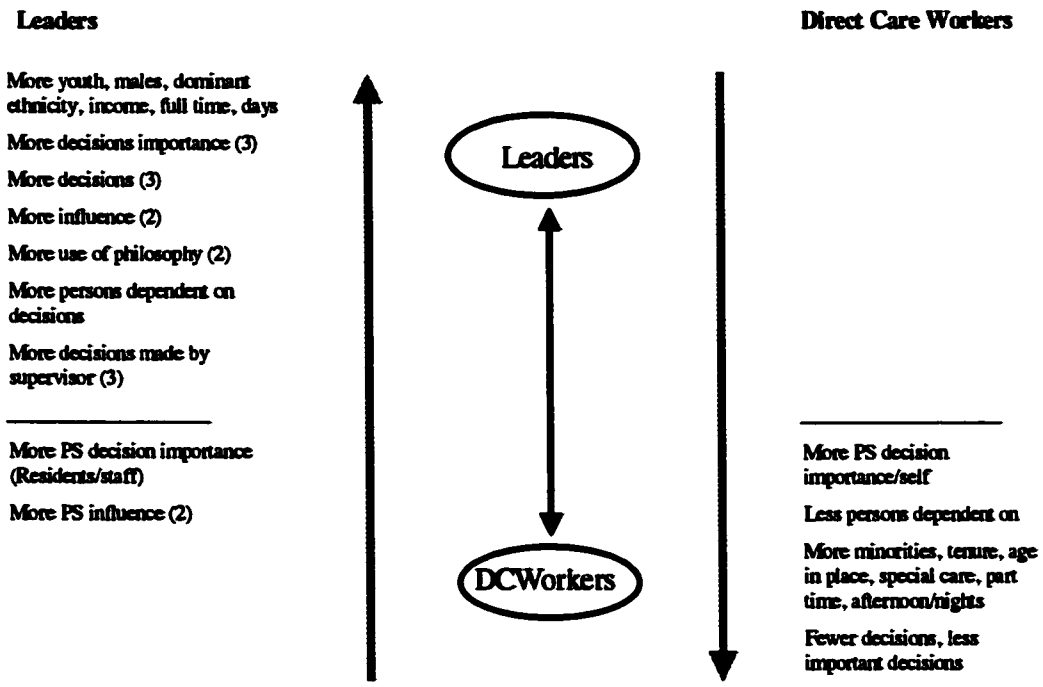
up by describing the home as "a caring centre for living and learning". Qualitative comments by staff about differential decision making power, confirmed "management does the decision making. We do not have choices as staff." When leaders feel they do not make decisions, the pursuit of excellence may be difficult for them to achieve.

Managers also reported little decision-making power. This fact suggests the construction of an additional dyadic unit which places the Ministry of Health at the top of the hierarchy and the Regional government and home administrator in the secondary position; however, the authority that comes from the Ministry of Health was not measured. Nevertheless, directives imposed from external sources such as the Ministry and the regional government may control the directives that get acted on, who makes decisions and which decisions they make. These invisible sources of control were neither visible in the facility nor available for this study (Lukes, 1974; Cutting, 1994).

Leaders and direct care workers.

While Figure 4 demonstrates similar differentials for the most part between these groups as in the previous groups, a few points will be highlighted. Where workers have less power, as these direct care workers do, they take on a "feminization" of roles, becoming passive and for the most part, compliant, assuming the stance preferred by the superior (Ferguson, 1984), and as they do so, they may also become participants in the oppression of their clients. (Mills & Simmons, 1999). These are the workers who have little

Figure 4: Decision Power Dyadic Unit II



authority, but much responsibility (Haddad, 1994, p.77).

But an interesting contradiction exists in this dyadic unit demonstrated by the groups' differential view and use of the home philosophy. For direct care workers, the importance of decisions particular to their work with residents related to other aspects of decision making, including their use of the philosophy; but this was not true for leaders. Like managers, leaders used the

philosophy more often and believed others used it less, but the more decision-making power they gave to supervisors (SIDM-PS) the less they used the philosophy themselves. While leaders also complied with supervisor preferences, that compliance interfered with their use of the philosophy. Direct care workers, on the other hand, actually admitted others used the philosophy more often than they themselves did; their use of the philosophy depended on how long they worked at the home, but also on how important they felt their decisions were, particularly about residents and themselves.

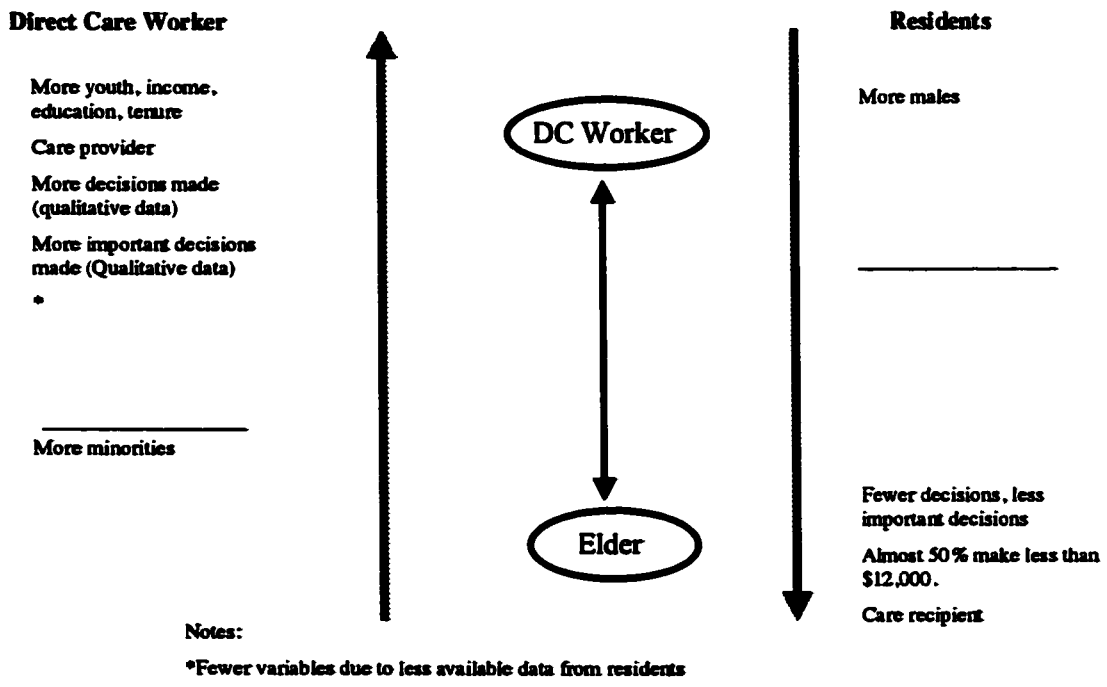
Comments made by workers reflect a real desire on the part of workers lower in the hierarchy to have increased decision-making authority. Statements such as the following were common: "I think health-care aides, PSW's (Personal Support Worker) and RPN's (Registered Practical Nurse) should have the say. We work with them (residents) all the time."

Dyadic Unit III: direct care workers and residents.

The examination of the relationship between direct care workers and residents (Figure 5) showed less differential power between the poles than in the previous two relationships, in part because residents only participated in a modest number of measures. Although only a small number of measures were used with residents, qualitative findings enrich the quantitative findings. In this relationship the primary source of power may arise from the relationship of care itself (Hugman, 1991).

While the study did not ask directly about respondents' reasons for their

Figure 5: Decision Power Dyadic Unit III



participation, the difference in response rate between residents (over 80%) and staff (over 41%) was noteworthy. As well as their interest in being part of the discussion with the researcher, in almost all cases, residents were also quite interested in the questions posed, and often added unsolicited comments to their answers. Although one might suggest they answered as part of an overarching attitude of compliance, their eagerness to answer seems to indicate a genuine interest in questions about decision making in the home where they live.

Participant comments and observed decision behaviours confirmed that direct care workers made many more decisions, and more important decisions than did residents; the decisions they made were decisions about the basics of life for residents. "I take whatever they bring. It isn't always what I like so I don't eat very much... Snack decisions depend on if you are diabetic, the staff decide...We don't have much of a choice."

Observation data also demonstrated that even legally capable residents made only a small range of decisions that might be made by other legally capable adults. Tables 7 and 8 attempt to visually define the difference. Initially, when the counted observed behaviours on the special care units were plotted on a graph indicating the amount of decision influence the resident had, the resulting table (Table 7) implied that observed residents made many decisions. However, the decisions they made were in only a small number of decision categories. For example, observed residents decided 69 times to change location, to wander about, and 29 times to interact with other persons, mostly other residents. They also participated in personal activity such as singing, dancing, folding tissues, making repetitive gestures, and others. That table (7.0) also displays some of the decisions that were made by others on behalf of these observed individuals; in those decisions, others held more influence than did the residents themselves, such as in the area of toileting. In these staff controlled areas, few decisions were made.

However, potentially observable decisions which were not identified

within the Schedule of Observed Behaviours were perhaps more meaningful than those selected. Table 8.0 presents a comparison of decisions that might be made during a typical day by a capable adult with those reflected in the questionnaire completed by legally capable residents and with those decisions that were identified and counted during observation in the special care unit. In this comparison, the observed and counted behaviours of residents of the special care unit are an extremely minimalist representation of decisions reflected in the questionnaire completed by legally capable residents. Similarly, the decisions reflected in the answers of legally capable residents are but a minimalist representation of those decisions that might be made in a typical adult's day.

Residents were cared for, gave information to staff without a reciprocal information flow back, and had the fewest options (Ferguson, 1984). They were labelled, placed into care groups, and segregated (Ferguson, 1984). In most cases, they had to have permission or help to use the toilet, to eat or to sit in the dining room. They had little or no decision-making power, and even when they made decisions, those decisions were often compromised. For example, when residents who were cognitively impaired interacted with staff, it was the staff member who decided to interact, but when these residents interacted with residents, decisions to interact were controlled by residents. While cognitively impaired individuals made decisions about when and where to wander, they made virtually no decisions about their care. The unsolicited comments made by non-impaired residents confirmed they did not make as

Table 8.0: Observed, Questioned and Usual Adult Behaviours

Decision Behaviours	Observed Behaviours (Not Observed =n/o)	Resident Questionnaire Item (Not Asked=n/a)	Typical Adult Lifestyle
Decide to stay/move locations	Observed	Answered	Usual behaviour
Decide to participate in activity/not	Observed	Answered	Usual behaviour
Initiate interaction with other person/not	Observed	n/a	Usual behaviour
Decide where to sit/not	Observed	n/a	Usual behaviour
Decide to help others	Observed	n/a	Usual behaviour
Initiate participation in personal activity	Observed	n/a	Usual behaviour
Initiate trip to toilet/not	Observed	Answered	Usual behaviour
Initiate change of clothing/not	Observed	Answered	Usual behaviour
Decide to get up in morning	n/o	Answered	Usual behaviour
Decide to go to bed/room/not	Observed	Answered	Usual behaviour
Decide to eat/not	Observed	n/a -	Usual behaviour
Decide which food to eat/not	Observed	n/a	Usual behaviour
Accept care/not	Observed	Answered	Usual behaviour
Decide to have snacks	n/o	Answered	Usual behaviour
Decide to change or take medication/care plan	n/o	Answered	Usual behaviour
Initiate transfer to other place	n/o	Answered	Usual behaviour
Decide to have Shower/Bath	n/o	Answered	Usual behaviour
Select actual food	n/o	Answered	Usual behaviour
Initiate washing, shave, brush teeth, comb hair	n/o	Answered	Usual behaviour
Decide to use bedroom to take nap	n/o	Answered	Usual behaviour

Decision Behaviours	Observed Behaviours (Not Observed =n/o)	Resident Questionnaire Item (Not Asked=n/a)	Typical Adult Lifestyle
Help plan activity	n/o	Answered	Usual behaviour
Initiate/plan daily routine	n/o	Answered	Usual behaviour
Decide where to eat	n/o	n/a	Usual behaviour
Decide what activities to participate in	n/o	n/a	Usual behaviour
Decide whether to work	n/o	n/a	Usual behaviour
Decide how to spend money	n/o	n/a	Usual behaviour
Decide to spend money	n/o	n/a	Usual behaviour
Select time to eat	n/o	n/a	Usual behaviour
Select time to have shower/bath	n/o	n/a	Usual behaviour
Decide where to spend time	n/o	n/a	Usual behaviour
Select activity from range of options	n/o	n/a	Usual behaviour

many decisions as they felt capable of making, and these residents did have the legal right to decide for themselves.

Many decisions were not available for resident consideration or observation, but were instead made by others. This was true even where the individual was legally competent and did not qualify for a substitute decision maker, or when such substitute decision making was simply unnecessary. While substitute decision makers were important to assure key care decisions met the needs of the individual for whom the proxy acted, these decision makers might

not have been as necessary where decisions related to individual preference (Fienberg & Whitlatch, 2001). For example, elders may not have needed a substitute decision maker to decide when they arose in the morning, when they had a bath or shower and even where they spent their time.

While some choice was seen in the chart as residents of the special care unit were observed 69 times changing locations, it must be remembered that even this apparent choice occurred within a secure, locked unit; and, on three occasions residents were observed trying to go through the locked door. Similarly, while residents did decide to interact with other residents, interactions between resident and staff, on the other hand, were initiated by staff. Decisions that dominated the behaviours observed in the special care unit were of choice compromised.

A similar but less dramatic pattern existed when consideration was given to the questionnaire items completed by legally capable residents. Areas of potential decision which did surface as decision behaviour indicators during the observation phase with incapable residents, were not part of the decision questionnaire used with legally capable residents. Some might suggest that those decisional behaviours such as a decision to interact, sit in a specific chair, that were selected for observation on the special care unit should be choices available to all individuals, regardless of cognition.

Similarly, when comparing the decisions on the questionnaire completed by legally capable old persons with those decisions commonly made by a typical

adult, the decisions posed in the questionnaire were similarly simplistic. While legally capable residents felt unable to decide what they would eat, when they would shower and whether they would participate in an activity, questions pertaining to such decisions might not even be raised in a study of decision making with legally capable adults living a typical life in the community. These data suggested that many decisions that a normally functioning, legally capable adult assumes are called to question when one's home is a long term care setting.

These findings are particularly important for several reasons. A clue to the first reason can be found in an interesting irregularity where only 16% of staff respondents reported working often in the special care units, yet well over 50% of residents live in special care units. While there may be organizational explanations for this anomaly, these findings may allude to some of the invisible or hidden characteristics of decision-making power which exist in long-term care or in this facility (Lukes, 1974). Workers who do not work with residents of special care units may have more power, but that power is largely invisible within the organization and this study. Second, the relationship between the direct care worker and the resident is central to the facility and its mandate (Hugman, 1991). Third, it is the provision of care for another, that, according to Hugman (1991), influences the power held by the care providers, in this case the direct care workers. Finally, levels of perceived worker control have been associated with increased satisfaction and commitment (Spector, 1986) and these

direct care workers play a fundamental role in the labelling and dehumanizing that occurs for residents under their care (DeMontigny, 1995). These workers had more decision power than did the residents they cared for, but substantially less than either leaders or managers.

Although decision importance is a subjective quantification, particularly for those persons who have lost decision-making power, the perception of decision importance remains fundamental to their lives and care (Collopy, 1988; Kasser & Ryan, 1999). In fact, decisions still within the purview of residents who have lost so much take on more importance as the number of decisions diminish (Shawler et al, 2001; Rubinstein, Kilbride & Nagy,1992; Everard, Rowles & High, 1994). Among those small but significant decisions are decisions to walk the halls and to eat or not. These two decision areas may be representative of the small vestiges of power and control still remaining in the lives of cognitively impaired individuals. One might question the underlying meaning of decisions made by others to lock doors and control the food available to cognitively impaired residents. Legally capable residents also identified issues of control over their food selection and sometimes their movement. In regard to shower availability, a resident commented, "If you are not there, or in bed already – they write 'refused'." These and other qualitative responses and observation also suggested that autonomy was lost among residents, whether they were legally capable or not.

Summary of dyadic unit relationships

In each dyadic unit relationship, staff respondents closer to the top of the organizational hierarchy felt their decisions were more important and they had more influence than staff groups in the lower position. But these people at the top of each dyadic unit also felt supervisors made more important decisions and had more influence than they themselves had. Based on qualitative data, similar conjectures may be made about the relationship between direct care workers and respondents who were residents. When the three dyadic units are placed together, the originally predicted parallel relationship can be addressed (Figure 6). Regardless of the impact of different instrumentation for the groups, this diagram demonstrates the specific parallels that emerge from a comparison of dyadic units one and two, and also of dyadic units two and three. Figure 7, then, provides a demonstration of only the differentials of decision-making power that exists consistently across all three dyadic units.

Within the prime working relationships (or dyadic units) the variables which represent income, the importance and number of decisions, and the tendency to work or live on a special care unit were repeated characteristics of decision-making power, of lack of power, across the entire spectrum of respondents, dyadic unit by dyadic unit. However, the diagram developed thus far still omits some important findings in the study, that is, the results of multiple regressions and T Tests. These two tests reveal overall similarities or patterns in the data in a comprehensive, statistically sound way. There is more

Figure 6: Three Dyadic Units - Two by Two

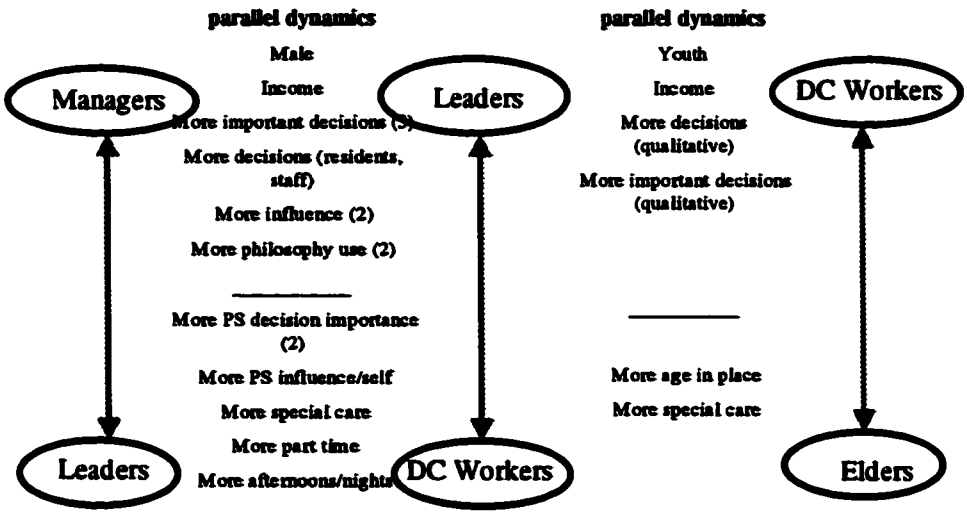
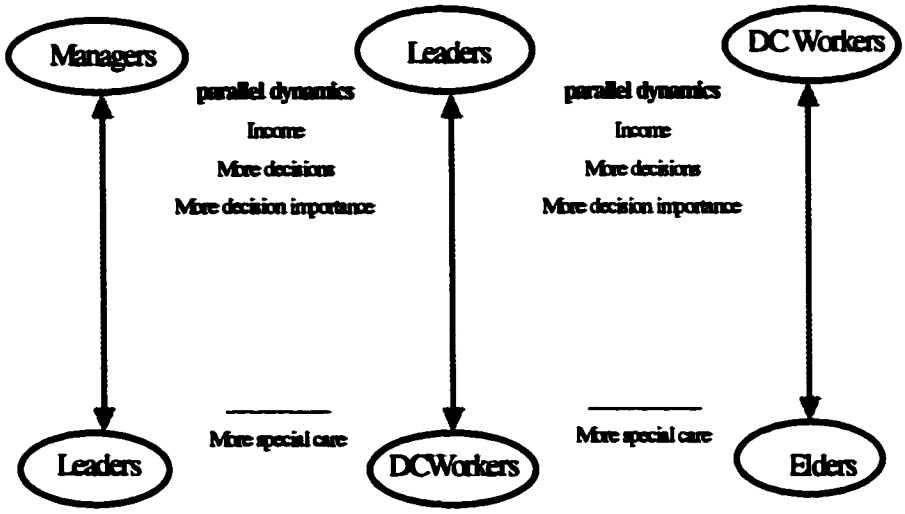


Figure 7: Parallels Across the Spectrum



to this representation than simply the parallel features illustrated in Figure 6 and Figure 7.

After discovering the scales (SIDM and SIDM-PS) correlated with each other, the regression models exposed the nature of the interrelationship between similar scales (Tables 6.0, 6.1, 6.2, 6.3). While scale scores themselves were not significantly related to the hierarchical position of the respondent, the interrelationship that did exist, still relates to the original hypothesis, but not exactly as it was originally stated. That is, the respondents' perception of their own decision-making power could be predicted by their perception of the supervisor's decision-making power, both in terms of the care subscales and the main scale. In fact, the models emerging from regression analyses clearly established that more than 40% of any change in a respondent's scores on the decision-making scales could be predicted when we knew their perception of superiors' decision-making power. Furthermore, the reverse was also true; the respondents' perception of the supervisors' decision-making power was also predicted by their perception of their own decision-making power. This regression result established a clear and important relationship between the perceptions workers hold about their own decision-making power and perceptions that those same workers hold about the decision-making power of supervisors. The relationship between the scales and the personnel groups was more complex than originally conceived (Figure 8).

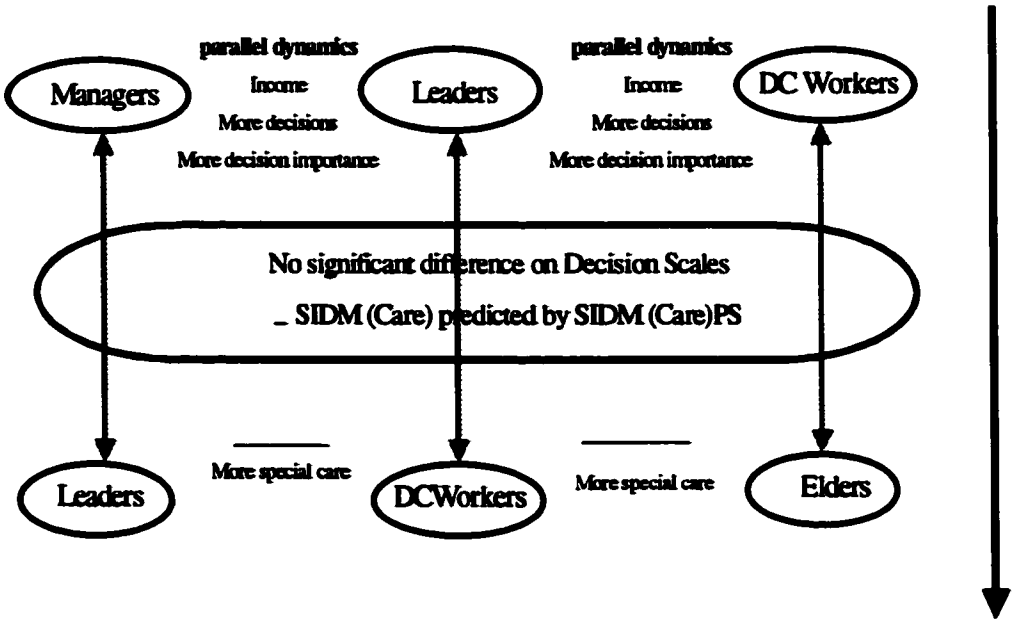
The strength of the regression models and the absence of T Test

significance when the groups were compared by dyadic unit is particularly striking, both statistically and otherwise. In fact, the developing model is similar to the hypothesis, but more complex than was originally stated and illustrated. Moreover, this complexity is the initial indicator that the concepts and complexities of chaos theory will hold fast with these results. The message from participants in this study is that while there were many similarities in descriptive and demographic data between personnel dyadic units, there were also some common reactions across the entire population.

Each scale variant also correlated with the respondents' perception of the supervisors' scope of influence, a finding that is reminiscent of the regression models that developed. In other words, as workers scored higher on each decision-making scale score, their perception of the superiors' influence also increased. Both the regression models discussed in the previous paragraph and these particular correlations describe a relationship between the respondents' own decision-making power and their perception of the supervisors' decision-making power. However, when this relationship between the scales and the respondents' perception of the superiors' influence was further broken down by personnel groups (Table 4.5), the correlations between all the scale variants and the perception of superiors' influence were strong and consistent only where respondents were direct care workers.

Other interesting, although not statistically significant and therefore highly speculative, trends were observed. While these trends provide only an

Figure 8: Converging Parallels of Decision Power



interesting departure here, and may be spurious, they may indicate a direction for related future research. In the main scale (SIDM) and its subscales, managers' mean scores were higher than leaders', and leaders' were higher than direct care workers' and, in the Care Subscale with Added Items, the only scale completed by residents, residents scored the highest. While this trend in resident scores seems incompatible with staff responses, it is not. Residents were answering questions about the influence others have in their lives whereas staff groups answered questions regarding how much influence they have in the lives of residents. It was also interesting, though similarly speculative, that when workers considered the decision-making power held by supervisors regarding care, this tentative pattern reversed; managers scored lower than leaders and leaders scored lower then direct care workers. This seeming contradiction, which extends across several scales and relates to all groups, is an indication that the parallel results already shown may have a degree of complexity not yet described or illustrated. That complexity may be compatible with the chaos principle that similarity and difference can co-exist. The fact that Independent T Tests revealed no significant differences between the scores on decision scales attained by personnel dyadic units, or between personnel working different schedules, shifts or work units is quite remarkable given that the actual mean scores do show this inclination.

It must be recognized that among these personnel groups within most organizations, administrators have the most influence overall (Connor, 1992;

Smith, Discenza & Saxberg, 1978). The results of this study indicate that worker's decision-making power is integrally linked to that of her boss, and the boss' decision-making power is linked to the worker's, whether in relation to decisions generally, or only in relation to care. How workers believe their boss feels about the boss' own decision-making power, predicts how those workers perceive their own decision-making power. Furthermore, at no other organizational level were the respondents' scores on decision-making power more connected with the supervisor's perceived decision-making power than at the direct care worker level. And in all cases, the relationship between the respondent's decision-making power and the supervisor's decision-making power was strongest when only those decisions related to care were considered.

These results raise interesting possibilities. For example, managers reported that a mean of 14.42 persons (Table 4.1) were dependent on their decisions, a substantially lower number than that suggested by leaders (21.50). But in the light of the regression models, one might question whether those managers were fully aware of the extent of their decision-making influence. The importance managers place on decisions they make about residents related strongly to how important they felt their decisions were about staff and also about themselves; this is compatible with Rutman's (1996) claim that powerfulness is felt when women's views are valued. When managers, who were mostly women, felt their decisions about staff and themselves were important, they also felt their decisions about residents were important. But the

regression model also suggests that how much decision-making power workers feel can be predicted by their perceptions of how much decision-making power they believe supervisors feel in their own decisions. One might argue then, that in order for leaders to feel decision-making importance, managers need to feel a similar importance in their own decisions, and that, in turn, relates to managers' perceptions of their own decision-making power. This argument, compatible with Kanter's theory of homogeneity (1977), suggests a butterfly effect (Gleick, 1987) similar to that proposed by chaos theorists.

While leaders identified that more people depended on them than did other respondents, they also felt superiors made astronomically more decisions than they themselves made about residents, staff or self. Leaders' own decision importance scores did not correlate with any other variable, and their perception of the superiors' decision importance scores only correlated with their perceptions of the superiors' decisions about self. While different from the results reflected in the previous paragraph about managers, these results are also consistent. Leaders believed superiors had more decision power, and that power related to the superior's decision power related to self.

When these results are considered simultaneously with the regression models, one might argue that if a manager wished to empower direct care workers to feel more decision-making power, these leaders (who feel so disempowered in making decisions), would need to make more decisions in relation to those many people dependent on them (Harlos, 1995). The

regression results showed that the decision-making power of workers is predicted by the perceptions held by those workers about superiors' decision-making power. A similar dynamic may exist for residents. In fact, Kane (2001) proposed residents will be treated as staff are treated. Residents might feel more decision-making power if direct care workers feel more decision-making power.

According to these results, when managers feel they have enough decision-making power, or at least are perceived by leaders to have enough decision-making power, leaders will feel they have enough. Similarly, when those leaders have, or are perceived to have, enough decision-making power, direct care workers will feel they have enough. And, most importantly, one might argue that when direct care workers have enough decision-making power, residents' perceptions of their own decision-making power will be enhanced. "Power begets power" (Kanter, 1977, p.168), and it may be that powerlessness, or near powerlessness, also begets powerlessness. This is a commendation for more decision-making power at each level down through the hierarchy. As local managers feel more self determining, leaders and direct care workers can be predicted to then feel more self determining. And if each level of worker actually makes more decisions, a consensus style of management may be possible. When residents become more self determining in this facility mandated to provide care, that care will be enhanced (Ferguson, 1984).

The similarities reflected in the T Tests together with the capacity of

scores on one decision scale to predict scores on another decision scale seem to throw the results found thus far into turmoil or perhaps one might call it chaos. Here in the face of differential decision power, there are similarities — a complexity of repeating patterns defined the decision-making power in this facility. Although the parallels are already striking, there are other indications of similarities as well. Women of lower income dominate these personnel groups, where both clientele and staff seem older than what might otherwise be the case in health service settings. The relationship of caring for, and receiving care may be another complicating factor in what seem to be somewhat homogeneous interlocking systems of both decision-making power and of disadvantage.

Implications of giving and receiving care

A comparison of the decision power and disadvantage of direct care workers and non-direct care workers (Figure 9) allows for tentative extrapolation about the impact of the environment of care. While direct care workers scored higher than non-direct care workers on all resident-based single measures, and felt more influence overall, they did not score higher in the use of the home philosophy. Though they recognized they had more decision-making power, they did not use the philosophy. Non-direct care workers, on the other hand, claimed to use the philosophy more often than others and believed they were seen by others as more influential.

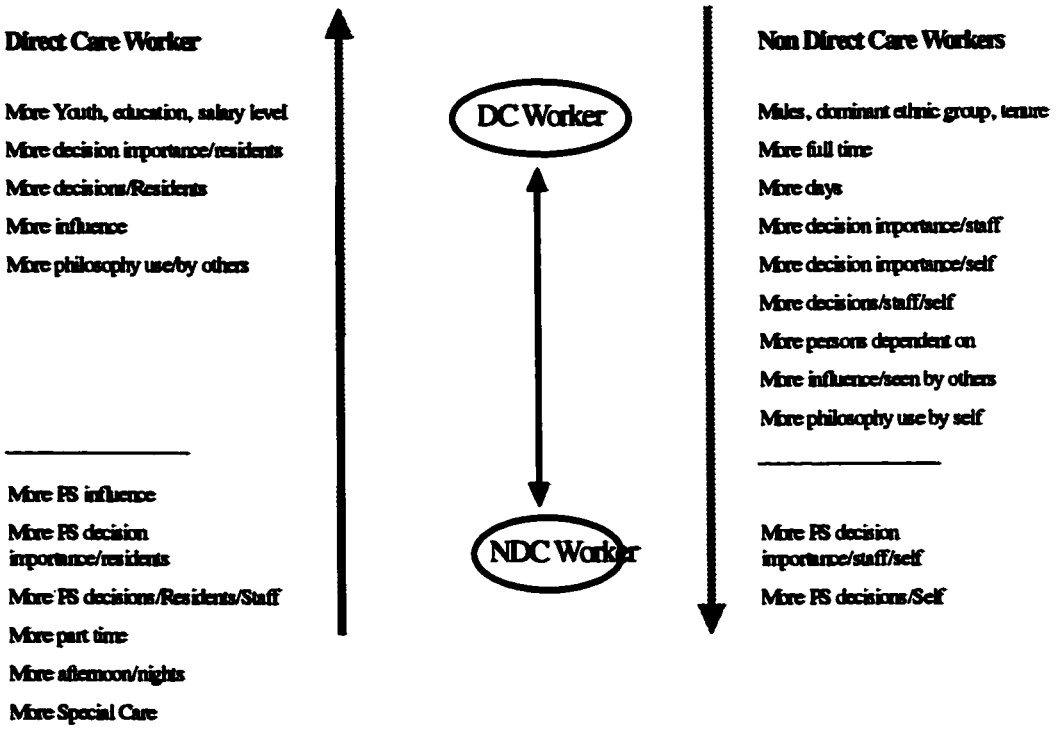
Interestingly, non-direct care workers identified a similar number of

persons dependent on them for their decisions as did leaders. But, while it is indisputable that residents were dependent on the decisions made by the direct care workers and others, the number of persons identified by direct care workers as dependent on their decisions was so low that these workers could not have included residents in their count; is this perhaps an indication of the role direct care workers play in the dehumanizing process (DeMontigny, 1995)? This demonstrated a difference between non-direct care workers and direct care workers; they felt quite differently about the decisions they made and the importance of their decisions.

Qualitative data showed that in spite of the reduction in wages, workers sometimes transferred from direct care to non-direct care roles. Was this move simply, as was suggested by key informants (A, B & C), a means to control their schedule and their stress? Or, could these transfers have been, in part, related to decision-making power? Or one might conjecture that individuals sought this move *because* they adhered to the philosophy and they could not stomach the role of direct care worker in the face of unstoppable cutbacks and restraints.

If, in addition to their stated commitment to the well-being of residents, these workers felt forced to work in a warehousing environment due to a lack of available employment options, they may have felt compelled to change roles. Workers who replaced direct care with non-direct care may have been taking a serious step whereby they could follow the home philosophy and avoid the

Figure 9: Decision Power of Direct Care and Non-Direct Care Workers



responsibility of both saying no to a needy resident, and withholding care. Instead, some may have chosen to scrub floors and cook meals where there are fewer restrictions and perhaps, less attention from superiors. And here, they felt a small measure of satisfaction with their work and of personal control (Fusco, 2002).

In fact, there was only one significant difference found among the T Test

results. The significant difference that did surface was between the direct care workers and the non-direct care workers (Table 5.0), and that statistical significance held fast for all of the scales used. While this was not one of the dyadic units in the original hypothesis, it does lead to an unavoidable question. That is, what is the relationship between care giving and decision making in this setting? While the scores of respondents in each care giving dyadic unit (managers/leaders, leaders/direct care workers, direct care workers/residents) do not show a significant difference, the scores of respondents who do not give direct care are significantly different than those workers who do give care, on the same decision making measures. The most obvious factor that may partly explain these differences is the giving and controlling, or receiving, of care by all respondents except the non-direct care workers who scored differently on the decision measures. There seems to be a relationship between care and decision-making power.

Application of Theoretical Frame

At the beginning of this dissertation, chaos theory (Prigogine and Stengers, 1984) was introduced as a theory of change and creativity, a theory that might offer a new view of organizations and the decision-making power within them. Weber's (1947) bureaucracy, for example, seeks stability and order through such mechanisms as hierarchy, the machine metaphor, control of uncertainty, determinism, uniformity and equilibrium. Prigogine and Stengers (1984), on the other hand, founded chaos theory on the belief that new entities

arise from chaos; this is a theory that proposes non linearity, multiple component parts, feedback spirals and self organizing energy. The chaos element of particular interest here is the fractal, described as "exposing the geometric nature of chaos". (Mandelbrot, 1983, p. 25). The next section of the dissertation builds and clarifies specific links between these results and the main concepts of each of these theoretical perspectives. Finally, overarching concepts of organizational and societal power will be considered.

Weber's Bureaucracy

The machine metaphor.

The relevance of the Weberian concept (Weber, 1947) of the machine to this long-term care facility crystalized in the key informant's (Informant B) explanation that workers protected their units to keep them functioning like "well oiled machines". Front line staff complied with the standards of efficiency that came down the hierarchy to them; at times even the physical movement of both direct care providers and residents was, itself, machine-like. Staff methodically folded the socks and washed the wheelchairs while 'wandering' residents followed the same path in the same hall day after day.

Rationality and documentation.

In an attempt to control uncertainty, contain costs, and to give at least the appearance of accountability and rationality, the Ministry of Health has established standards of compliance; long-term care facilities comply in order to get the necessary funds. Through the Provincial Resident Classification Form,

nurse classifiers evaluated more than 60 items of information previously recorded by home staff about each resident (Ministry of Health, 1995). Items included i) in regard to feeding "encourage intermittently, open cartons, cut meat", ii) in regard to toileting "requires assistance with clothing, supervise in getting on and off toilet for safety" and iii) several behavioural items such as "hoards", "inappropriate dresser", "wants to go home" (p. 1-17).

This classification system demanded that home staff continuously monitor and document each process of care as it was delivered. Typical of Weber's bureaucratic hierarchy, these nurse classifiers did not actually assign the care levels on which funding would subsequently be based; instead, provincial bureaucrats made those decisions at head office (Ministry of Health, 1995). Increasing levels of frailty at the time of admission put further pressure on the facility and staff for copious background documentation. Detailed documentation requirements to prove, for example, the level of care of a recently admitted person with dementia demands a level of observation that may not be possible with current staff levels. And furthermore, Foner's (1995) study identified that when direct care workers spend countless hours documenting the care, they have less time to give it. Yet without that observation the funds required to care for this individual's needs will not be justified.

Determinism, control, and routinization.

As problems surfaced in this home, they were often solved with a clarification or bolstering of a particular care routine, or the development of a

new process to impose control. That control, justified by the politicians and bureaucrats managing the system with an argument of cost containment and rationality, may be the overarching goal of the long-term care bureaucracy. Certainly, residents and staff at all levels expressed that they felt controlled by others and that they have been unable to make many, or any, decisions. Yet, paradoxically, one informant stated that the home "feels out of control to me" (Informant B). Uncontrolled resident behaviours, cognition, and bodily functions, together with the reported unrealistic expectations imposed for documentation and more work with less staff, continuous demands for care, and seemingly unrealistic expectations arising from inadequate funding levels may be increasing the turmoil rather than controlling it.

Both staff leaders and direct care workers put strategies of control into place in their interactions with residents. One staff member said that care routines had been in place for many years. "Work is very routine – (the) only change is new resident, illness or death of resident, the rest is routine." Workers spoke of being unable to go to their break until the routine was complete, yet on the other hand, residents feared being left naked in their bed while staff took a break. Workers documented care, washed and dressed residents, and took breaks according to a rigid schedule that defined who did what, and when.

In an environment where the agency mandate has been to provide care for people with little control of their environment, their care or even their most basic of bodily functions, issues of control have become paramount. And many

of these care recipients have lost the legal right to make their own decisions. There are few persons on earth with as little decision-making power as this population of people — the frail institutionalized elderly. Certainly attempts to control a potentially frenetic situation and those within it, must have seemed natural enough. And so the Ministry controlled through standards of compliance, and the Region controlled through financial constraint, policies, staffing ratios and demands for documentation. Managers then assumed that control which originated further up the organizational pyramid and operationalized that control through scheduling and managing who does what — down to the finest detail. Quite simply, this was, perhaps, the only strategy they had at their disposal, and so they used it (Kanter, 1977). The rules of the bureaucracy defined how and where one person could impose their will on another.

Hierarchy of functions and people.

During the study, the routinization of care just discussed pervaded most areas of the home, as those higher up the ladder planned activities and tasks for others down to the last detail; and residents and staff filled their required roles, shuffling through their days. The routine was clear, documented and compartmentalized in a way that ensured that as front line workers provided care, the level of work, efficiency, and ultimately costs, were controlled. The chaos was kept at bay, or so it appeared.

Micro managing occurred at each level down through the organizational

structure as each successive personnel group attempted to control uncertainty — an effort that seemed even more necessary because of too little money and too much frailty. Workers simply used the mechanisms of control they had at their disposal, functioning like machines in an environment that required compassion. A staff member displayed this mechanized approach. "Do you want to sit over here? You have to sit over here." Another disillusioned staff member described her world of work. "On many occasions I feel as though I have to do all the thinking for those working with me. At times I wonder if other workers do not have eyes and ears and common sense." Staff were afraid of change, afraid that change would only mean more work for them (Informant A). They may be victims of the cynicism and burnout that can accompany too much human care giving because of, or in spite of, their compassion for the recipients of their care.

Application of Chaos Theory and Fractals

Much of this work reflects a finely tuned organization, part of an immense hierarchy. But, the age of the machine has ended, and the system offering long-term health care must deal with people, not machines. It may be that although this facility and its sister organizations are run with machine-like efficiencies in mind, they are actually seeking to "control chaos" as was predicted by Prigogine and Stengers (1984). Chaos may originate from the strain that surfaces when excessive care demands meet declining resources, particularly where the demand comes from disadvantaged individuals. This

section of the paper will address these results using applicable chaos concepts — the flow of energy and power, complexity, linearity, multiple intersecting parts, creativity and particularly fractals.

A theory for today's people.

As we move away from the age of the machine, an issue of prime relevance when discussing chaos is that of human nature. "The systems through which we administer ourselves, have become estranged from the social relations by which we define ourselves" (Sossin, 1994, p. 367). The fundamental nature of human beings may be contrary to widely used organizational strategies, including those of this facility, but compatible with the chaotic systems defined by Prigogine and Stengers (1984). Human beings may even thrive in chaotic situations. While chaos thinking seems compatible with human nature, Weber's bureaucracy does not seem as compatible.

A flow of energy and power—restrained.

One of the goals may simply be to control the chaos just beneath the surface that arises from the nature of resident disability, the disadvantage of most people in the system, the increasing care demands, the demand for cost cutting efficiencies, and the declining resources available for increasing numbers of elders. This may be an excellent example of workers seeking to control chaos — in a facility where workers and managers alike feel powerless, and where care recipients are frail cognitively impaired elders.

While Weber's bureaucracy is balanced, as everyone has a role,

functions are divided and rationality is the goal, chaos writers discuss a flow of energy. There may also be a flow of power through a chaotic system. For example, in this facility, managers have more decision power than leaders, leaders have more than direct care workers, and direct care workers have more decision power (related to care itself) than residents; here and perhaps everywhere, decision-making power is hierarchically based. People at every organizational level experience limitations to their own decision-making power but attribute a greater power to those above them in the hierarchy. This is as true for managers as it is for leaders and front line workers. But, this dynamic of formal care giving transpires while recipients of care simultaneously have incredibly little decision power. At every organizational level, individuals feels deprived of decision-making power. The fact that the workers' perception of the supervisor's decision-making power then predicts that of those workers lower in the hierarchy indicates that while people look up for direction in determining their level of personal decision-making power, they are, in fact, looking to someone who perceives that they themselves do not have enough decision power. This then predicts that those looking up for direction will have similar perceptions. The flow of decision power, and its absence, in the organization seems circular.

One might question whether this flow or blockage of power originates from the powerful entities at the top — the Ministry of Health, the Government of Ontario, and the Government of Canada. Or on the other hand, perhaps a

flow or blockage of powerlessness originates at the bottom with the need experienced by cognitively impaired, frail elders who have control over few aspects of their lives, or control of nothing. Perhaps, compatible with chaos theory, both are true.

Within this long-term care facility, most decisions of consequence are made from afar by invisible bureaucrats. Two additional and undisputable facts must be acknowledged. Clients of the facility need care; and many of them have legally appointed substitute decision makers. Such a situation of *restrained control* on one part, may invite other players to assume control. Where people feel powerless and service recipients have control over virtually nothing, even of their cognition and their bodily functions, rationality may not be possible; the situation is chaotic. This may be true even in the face of strident attempts to control that chaos. But, the desired result of care preferred by those in power in Ontario in 2002 is decreased cost and more efficiency — and from the interface of these two goals, a bureaucratic argument is made to control the chaos. Here, as Prigogine suggested, humans seek to control chaos.

When we consider this power/disempowerment circuitous dichotomy from the other side, the management side, we must recognize that the provincial Ministry of Health together with the federal Department of Health and Welfare, are powerful, controlling entities, themselves controlled by political masters. This has never been more true than when both bodies are functioning under the mantra of cost cutting efficiencies, as a gerontological boom is well underway.

As these bodies impose massive compliance standards together with cost containment exercises, those below them in the system can only comply. In long-term care, in an attempt to control and rationalize, the flow of energy and power may be paralysing staff, elders and the system itself.

Nevertheless, the compassionate humans who work to provide care at the bottom of each personnel dyadic unit, interacting with, or seeing care recipients on a daily basis, may have some good ideas of how to provide care. An example of this phenomenon can be heard in the informant's (Informant A) words when stating that sometimes the managers do not really understand the needs of the front line workers. In the face of the power emanating from these government bodies, those lower in the structure with little decision-making power may choose to do what they can to secure a small measure of control for themselves, and they may do this at the expense of the individuals below them in the organization.

Linearity and complexity.

Unlike the ideal bureaucracy, chaotic systems are not linear. While attempts have been made to establish linearity in this facility, it has not been achieved. For example, the attempt to segregate cognitively impaired from those who are not has not been successful; when residents live in the Age in Place wing and then become impaired, they usually remain in the same wing. Similarly, workers in each category are not as identical as job categories might predict. Workers sometimes change categories, moving from direct care to

non-direct care. Care planning itself is not as linear as the systematization might indicate; crises of care continue to happen. The elder makes demands to go to the toilet at a time other than the time scheduled. Cookies purchased for residents from the $4 allotted daily to each resident for food are eaten by students helping as volunteers. And in this research, the relationship between the scales and the personnel groups was more complex than originally conceived, more complex but yet similar. Attempts to assure linearity and consistency are not often successful in a chaotic system.

Boundaries and multiple intersecting components.

Rather than controlling chaos, its theorists allow for the co-existence of chaos with order, and of complexity with simplicity. And it is from that complexity and chaos that creative new entities may arise such as, in this case, a new form of compassionate care. Multiple intersecting components work together as defined by Prigogine and Stengers and Zimmerman (Prigogine & Stengers, 1984; Zimmerman, 1996, Zimmerman,1994). Workers at all levels, interacting with each other and with residents in all units and with their families, provide an example for this point. In this relatively small living community, most workers know everyone in the home by name. When I visited during night shifts, several workers approached me to tell me "how it really is" at the home. Even residents who were involved and engaged in the life of the home offered feedback to me, and likely to others. The feedback loops common in chaotic systems swirl through every intersection in the organization. Where chaos

exists, decision making cannot be restricted to only what can be routinized.

Creativity.

In a chaotic system an opportunity for creativity exists at the "edge of chaos" at the "point of tension". Yet, in this facility, when problems surface and chaos looms, at the point defined by chaos theorists as the "point of bifurcation", the response is to seek greater control. Routines are enhanced, policies are finely tuned and rewritten and stricter compliance standards are imposed. Staff respond that they do not have decision-making power, and yet, one staff comment conceded that, in fact they do have some control in that they can choose whether to come into work each day, or not. And this creative response is a source of difficulty for residents, workers and managers alike. When workers call in sick, others must fill in. And when those workers are direct care workers, the care must be given, regardless of the work stress it imposes on those who ARE on the job that day. And so, direct care workers move on to become the non-direct care workers and then report using the home philosophy more frequently then other workers, they feel more influence in the eyes of others and they make more decisions about their own jobs; and those are decisions that impact on other workers. This seems to be a chaotic system where chaos may not really be controlled after all.

And as residents begin to respond creatively to situations of control as might be expected by chaos theorists — for example, when they seek to remain in the dining room beyond the allowed time, or when they try to leave the

restricted area — they are stopped; a routine that demands compliance is implemented. When workers feel unable to cope, ready to collapse from burnout, they stop themselves — they stay home "sick", go on leave, or instead choose to continue to play the game, but as a housekeeping aide, or a maintenance worker. While the atmosphere of chaos continues, the "edge of chaos" has been extinguished—at least temporarily.

Fractals

Chaotic spirals of restraining power.

And so we have a series of spirals of descending decision power as personnel at each level feel more decision power than those who are beneath them in the hierarchy, but less than those above them. But these are not the linear relationships indicated in the diagrams proposed thus far. First, the downward direction is convoluted by the fact that each group that is lower in the dyadic unit is also more connected, via the organizational mandate and their own job descriptions, to those with the least decision-making power, that is, residents, especially those who are cognitively impaired. While this reinforces the diminishing power, the relationship is more circular than linear. Both direct care workers and leaders have more connection to special care and higher care scores than do groups at the top of Dyadic Units I and II. In fact, when qualitative data are interjected to compensate for those quantitative measures not completed by residents, much of the data collected demonstrates that each group higher in the hierarchy has more decision power than each group lower.

A second complexity that prevents a clear linearity in power dynamics is that in spite of that decision-making power, or perhaps because of it, higher groups also used the philosophy to a greater extent than the lower groups, with the exception of those who opt out of the descending spiral. Third, while regression models indicate a clear relationship between worker decision-making power and their perception of supervisors' decision-making power, the decision-making power between groups varies, with direct care workers ascribing the most decision power to the superior. As in a chaotic system, the results are both consistent in some ways, and inconsistent in others; these are not linear relationships. Nevertheless, there does seem to be a flow of decision-making power that indicates those players at the top of each dyadic unit have more than those at the bottom of each dyadic unit. Order and chaos co-exist simultaneously.

The picture becomes even more complex when we add, then, the fact that there is no significant difference between the groups on the decision scales, but the same scales reveal some consistent, albeit dubious, trends. When we consider that the perception of superior scales (PS) and other indicators of decision power vary somewhat between personnel groups, we might question whether in fact there is a pattern at all.

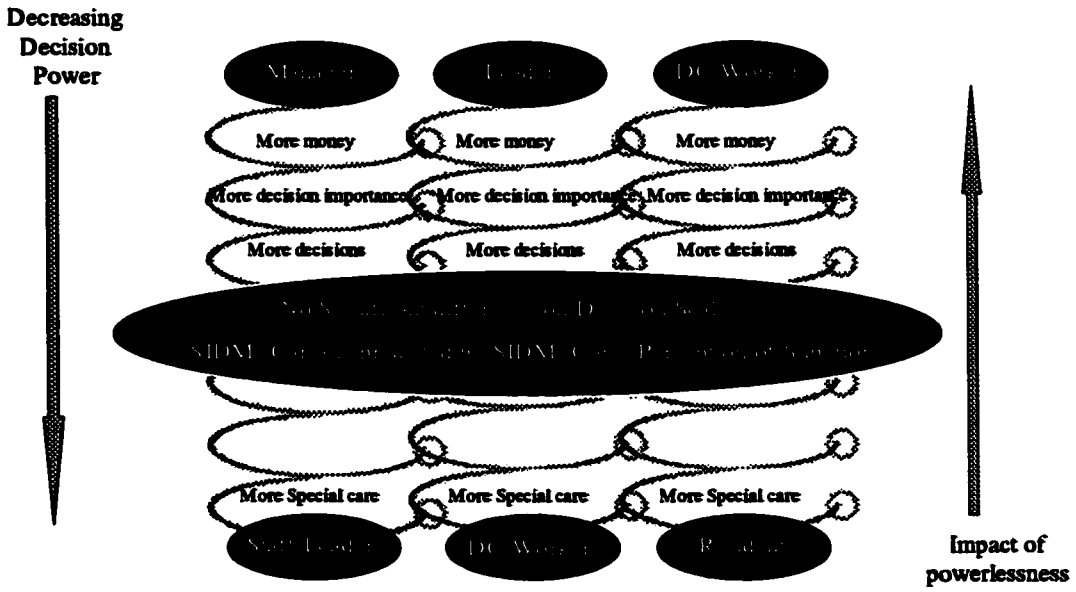
But, finally, the pattern begins to come into focus when we apply the multivariate results as an overlay on the descriptive and bivariate results (Figure 10). While respondents' views of supervisors' decision power vary, the

regression model demonstrates that the decision-making power held by personnel can be predicted by their perception of the decision-making power held by supervisors. The lines of decision-making power as it diminishes or escalates are not straight lines, but might rather be conceived of as interlocking downward spirals of decision-making power. Parallel spirals of diminishing decision-making power are held together by the similarities of income, work type, gender, and more significantly by decision-making scores and the ability to predict perceived decision power held by workers through their perceptions of superiors' power.

It is these last items then that connect the spirals of declining power to one another- interconnected downward spirals of decision-making power. The care needs and level of dysfunction of residents and the decision power held by the Ministry of Health, operationalized through compliance guidelines and standards of care, reinforce and maintain the momentum through the spirals. The lack of decisions, the imposition of directives from above, and the frailty of the residents create a system where life is habitual and mechanistic and where rationality is both revered and disputed (residents) and where creativity does not exist. Creativity is stifled and chaos controlled at each organizational level. While the goal may be to control chaos, the net result may actually be the opposite.

Here we have providers who seek control at every level. Clients at the bottom of the hierarchy respond to that demand for control with creativity, as

Figure 10: Converging Spirals of Downward Decision-Making Power



predicted by chaos theory. A resident spoke of sneaking out to a chiropractic appointment unknown to the providers. Another, having been told he would not be able to have mail delivery at the home, sent a change of address card to the post office and was granted personal mail delivery. And yet another throws her cup on the floor when the person delivering drinks moans and distributes the drinks with neither eye contact nor comment. Others steal food, perhaps to

compensate for a shortage of desirable food at mealtime. Even more astonishing is the fact that these creative responses occurred where residents have little remaining cognition. Is it possible to be creative even though one is not rational? Does creativity originate in rationality? Sigmund Freud and his followers claimed that creativity originates in the id, the unconscious, impulse driven, non-rational part of the human mind (Freud, 1905; Noy, 1969). The emergence of a creative response, particularly in the face of control, remains.

Like the fractals of chaos theory, these dyadic units of decision-making power are parallel in several observable ways, both vertically and horizontally. Attempts by both staff and residents to take control occur in an environment that has been described as one of machine-like control over everyone within it. Even the humanness of clients might be questioned by some who use words and phrases like "demented", "out of it", "vegetative state" to describe people who are parents and grandparents. Both staff and residents function, in large part, as passive, compliant entities, and yet, there is also an element of aggressive control alongside that passivity. This juxtaposition of passivity and aggression can be seen when a hungry resident responds to a staff person's offer of food, "Thank you. I can manage," or another angrily notices that students take the food intended for residents. Yet another steals food. While some staff mention their concern and commitment to residents, others moan as they work.

The chaos lens proffers a new view of this system, one that invites the acceptance of the fluctuating boundaries and change that would be compatible

with chaos theory. The latter could possibly create an environment that would allow for the development of creativity and empowered providers and recipients of care. Issues related to order and disorder, creativity or the stifling of it, personal autonomy or the lack of it, change and stability, will be relevant factors in this development.

More importantly, this relatively new theory of chaos offers a way to understand and structure decision-making relationships in organizations to maximize creativity. But in order to accomplish this we need to let go of our obsession with control. Our new ability to see the boundary between the control that exists prior to the "bifurcation" point (Prigogine & Stengers, 1984, p. 161), and the creativity that can be unleashed with the abandonment of that control, offers the key.

A manager who might accept that chaos exists, and might wish to capitalize on its existence might encourage the development of decision-making strategies at each organizational level. The resulting organization would in all likelihood become more chaotic. But it might also allow creativity to develop - beginning at whatever level that there is the least resistance.

Like the impact of a butterfly wing, a small change can create a transformative shift in the whole. This creative change will exist only as we accept and learn to live with chaos. As a counter-thesis to Newton's belief that systems move toward entropy and simpleness, chaos theory may also contradict previously held views about rational management and decision-making power

(Weber, 1947). When we seek a simple understanding of complex chaotic entities, the resulting synthesis can provoke new perspectives from which to view the homes that provide care to vulnerable older adults.

Application of power theory

This section of the dissertation links organizational power more clearly with decision-making, postulating that while decision-making may not precisely parallel power, it does offer a representation of it and has similar dynamics. Authors who have focused on power are countless; but the focus of this particular section is on the work of Lukes (1974), French and Raven (1959), Pinderhughes (1983) and Hugman (1991), as demonstrated earlier (Figure 1). Organizational power is demonstrated through three primary components: control, authority and influence. In each case, when we review these authors' words on this continuum of power, we can see that each aspect is achieved or expressed through decision-making by individual players. That decision-making may be subjective, it may be the decision to not decide, or it may be invisible.

To gain understanding of the relationship between power and decision making, the goal of the care infrastructure must be determined. In a somewhat simplistic yet accurate manner the resident's challenge said it all. "The government cut a way back. I don't think it is fair. They should put residents first...." Is the goal to provide compassionate care or to provide care that meets minimal expectations while cutting costs to the bone? And whose expectations

are long-term care planners seeking to meet? The residents of the planned facilities? The families who place them there? The care givers who provide care? The taxpayers? Perhaps, as Janice Gross Stein claims in her new book, *The Cult of Efficiency* (2001), it is when the end goal becomes efficiency and by extension cost containment, an end goal that replaces compassionate care, that we enter this world of mechanized care. One of the resident respondents used the word "mechanically" when describing the nursing care she received. Because caregivers, residents and families make few decisions, we must assume that it is the politicians and bureaucrats, and their stakeholders and special interest groups who make many of the decisions and establish the underlying goals. Is it possible that the bureaucratic goals of rationality, efficiency and planned work have themselves become tyrants in the lives of workers and residents? Does the tyranny of such rationality actually create its nemesis?

Have we as a society become lost on the path, focusing on the means rather than the goal? Albeit administrators would claim they are trying to use the system to meet their goals, that is, they are concentrating on policy, the adherence to standards and compliance expectations, perhaps with the belief that planners develop these standards to assure that goals are met. But is this the case? Each group of respondents perceives that they use the philosophy of the home more often than do others. But when we compare direct care workers and non-direct care workers, non-direct care providers use it more. Inevitably the discussion must turn to care. Although well-being and even mortality rates

have been related to one's ability to make one's own decisions, to be autonomous, (Bisconti & Bergeman, 1999; Campbell, Busby, Robertson, & Horwath, 1995; Kasser & Ryan, 1999; Eizenma n, Nesselroade, Featherman & Rowe, 1997; Pilisuk, Montgomery, Parks & Acredolo, 1993) non-direct care workers believe that they use the philosophy of the home more than do the care giving staff. What does this suggest, then, about the care?

Using chaos as a lens, and questioning whether the power comes down, or the powerlessness comes up, the answer will at least in part be answered by individual perception. At one end we find the all powerful Ministry of Health; at the other end, the frail legally incapable elder. The invisibility of these older persons, seen by some as non-persons, may impact on the direction of power. Is the absence of decision-making related to their status as almost inhuman, half dead, half alive. Perhaps Boulding (1989) was right, life is power. Is this a situation where we must simply store people, until they die? After they have lived out their usefulness in society? Is a long term care facility or home, actually a warehouse for used people? If that were truly the attitude that motivates, given that we are a society trying to save dollars, we would simply need an organized storage system. Is that not what we have? Yet, it is mostly the elders who attempt creative responses in the face of control. Is it possible to be creative even though one is not rational?

Perhaps when people say they have little decision-making power, it may be an excuse to do nothing. But workers do test the limits and make decisions -

when they call in sick. More often, it is elders who test the limits, when they act non rationally, steal food, or otherwise break the rules. Perhaps the reason that staff do not test the limits often is because they are already at the bottom of the chain of work available to them; they have few options. After cleaning the feces and drool for individuals who cannot provide themselves with even the basics of care, these workers know there are not other jobs out there for them. These are women, with low incomes, working in physical care giving roles — women who have little power already. Perhaps they fear losing the one thing they do have, the job — and so they do the work; they follow the routine and the rules (Fusco, 2002).

Do workers move from direct care to non-direct care positions in order to seize some personal power, so they can escape from the entanglement of sometimes unexpected care giving demands together with the cost cutting strategies imposed from outside? As non-direct care workers they can avoid feelings of helplessness when there is not enough time to give the care they want to give; they can scrub a floor and feel personally satisfied that they have done a good job. It is difficult to feel successful when you are working with people who are on the edge of humanity. As non-direct care workers they avoid the stress and demand that is central to the job of direct care giving. They can feel more successful at their work than they previously felt as caregivers: they implement the philosophy more than others, others believe they have more influence and they feel they make more decisions about staff and themselves.

Because of the level of both human need and demand, everyone is trying to get control — the residents, the direct care workers, the leaders, the managers and even the government planners and policy makers. But few feel they have it. These respondents and informants feel they do not always have enough decision-making power to do their jobs. And even as they impose the strategies intended to gain control - routine, documentation, behaviour control, compliance standards and even legislation - they do not gain control over the care. The end result is a different form of chaos than existed before the attempt to control it. And now, even more strategies become necessary. Power, as it is operationalized through decisions that assume control, both prevents and produces change (Boulding, 1989; Clegg, 1996).

The maintenance of control that originates at the top of the hierarchy can be seen at other levels in the organization. Similarly, the powerlessness, the machine-like routinized life that residents live, is seen at other levels in the organization. The dominant values, that is the cost containment and the warehousing of perhaps disposable humans, are replicated throughout the long-term care structure (Kniss, 1996; Tracy, 1998). Residents cannot decide where they live, what or when they eat or when they use the toilet. Direct care workers cannot plan their own work day, decide the day or unit of work, the work routine or when they do what. Managers cannot establish the standards of care that they would find to be humane and compassionate. The cycle goes on - converging downward spirals, parallels of power. Fractal-like patterns are

replicated on multiple scales.

This power of one person over another extends to relationships between professions and service recipients and also between the professions themselves. A key informant (Informant A) identified that non-direct care workers do not feel respected by nursing staff. Power-over, a social relation, also exists between older adults and the institutions that help them; professionalism is one key element in the 'taking over' that is part of providing care (Hugman, 1991, p. 12).

When acute care and science compete for resources with chronic long-term care and compassion, the predictors of power, that is, science, technology, medical model thinking and youth, line up with acute care. Where ideologies are questioned, professionals who work in long-term care may be in conflict and clients who live in the facilities, at risk (Ferguson, 1984; Hugman, 1991). Long-term care with its emphasis on custodial care of the old, the frail and the cognitively impaired, has less power at the resource allocation table. The bureaucratic long-term care system has evolved according to the wishes of the powerful, and that organizational power may hold a key to the well-being of those frail elders who live in long-term care facilities. Poorly used, that power can undermine elders' personal authority, independence and life itself and pose a similar but less severe impact on workers and managers. Although administrators, payers, family members and older adults themselves speak and write about the goal of maximizing health and well-being, too many long-term

care recipients and staff are powerless, sick and unhappy (Laurence, 1992).

Practice Implications for Social Workers

Social workers have provided leadership in identifying where individuals are discounted or abused in child welfare organizations, women's shelters and advocacy organizations -and we have made a difference. We sit at planning tables, participate in policy making, develop programs and provide direct service. Working where the client meets the environment, at the bridge between the everyday world of the client and the power brokers of society (De Montigny, 1995), social workers span the divide between the powerful and the powerless. We have the potential to influence the flow of decision making and power in a way that could lead to a more democratic, client -focused system (Dana, 1991). Where there are more social workers in care facilities, routine is less rigid (Kruzich & Powell, 1995). We can call for long-term care systems that allow even impaired residents to decide whether or not they wish to sit in the dining room following the meal, when they have a shower or a bath, whether they have fruit or a cookie for a snack.

In a world of competition between countervailing powers, social workers and our colleagues can strengthen the voice for participatory power at staff levels as well as client levels (Frankford, 1997). We can demand that elders make decisions and where we sit on interdisciplinary teams responsible for the delivery of long-term care, we can also support the enhancement of decision making for each downtrodden level of the team. Workers who are planners and

policy makers will recognize that Chief Executive Officers relate daily with care recipients, unlike government bureaucrats and politicians; as a result, these managers understand the needs of residents better. Social workers who sit at government policy and planning tables are in the position to push for more decisions to be made at this agency level.

Client-centred and empowered CEO's will recognize that staff managers and leaders are more able to understand the real needs on the units in facilities than they themselves are; those social workers who are CEO's themselves will be in a position to support front line managers who initiate client-centred, care decisions. However, the most important implication for social workers is for those who function as discharge planners, admission coordinators or often as the only social worker in a long-term care facility. These workers are in an ideal position to recognize client-centred decisions made not only by managers but also those made by health-care aides and other front line workers. Using their well developed people skills, these workers can focus their support on that front line care team. When each level of workers encourages those lower in the hierarchy to initiate decisions, if the concepts of chaos theory presented here are relevant, the path to creative solutions for problems at all levels will be found.

Social workers are often caught between the demands of our employers and the needs of clients (Fusco, 1983). And the social work ethical code demands that we take the power seriously (Sossin, 1994). In a world where older adults waste away in the back wards of long-term care facilities, sometimes abused,

usually unhappy, organizations are searching for new ways to work. The results of this study indicate that if we intervene at one level, the impact of that intervention may reverberate across the levels. As we build this new paradigm suitable for a chaotic world, we may find the strength and creativity of flourishing long-term care organizations (Kuhn, 1962).

Related Ethical Principles

The most basic and first principle of our Code of Ethics speaks to the primacy of dignity of the individual. This study has revealed that residents in long-term care facilities, and those who serve them, have little of the dignity that accompanies decision making. While this lack of dignity may exist at multiple levels, it is most obvious for the residents who are recipients of special care, that is, those who are cognitively impaired. While it is difficult to gain informed consent, and to conduct this kind of research with this population, these individuals have the right to participate in research that has the potential to improve their quality of life and perhaps, also, their care. Studying the realities of the lives of this group of residents in long term care facilities cannot be readily accomplished through information provided by proxy decision makers or providers of care. The research result may be more accurate if data come from the residents themselves.

Workers in the dyadic units demonstrated here may be members of a regulatory professional body mandated to assure their adherence to professional values. As social workers, for example, follow the principle of client need as

the first priority (Canadian Association of Social Workers, 1994), their proximity to disadvantaged elders will increase not only their own vulnerability (Hugman, 1991) but also their sensitivity to client needs and rights and also their unique view of care (Bowers et al, 2001; Bissell, 1996). Unfortunately, the social work foci on client dignity and strengths are inhibited by demands for compliance and by the concentration on problem identification that prevails in medical model thinking (Holden, 1991; Pray, 1992). With today's momentum toward cost containment, even the most basic among health-care goals are not fully met. Informants, observation and respondent comments each implied that custodial care continues in spite of the espoused organizational philosophy of care. And so, as social workers and nurses advocate for clients and strive for ethical social work or nursing practice (Canadian Nurses Association, 1998), they are caught on the horns of an ethical dilemma, between their own and professional values and the expectations of those with control over both care, and their jobs.

This domination in health-care decision-making practice of medical model thinkers (Holden, 1991; Pray, 1992) becomes more pervasive in the face of government demands for cost containment and the elites who control the measurement, funding and standards of care have the power. And in long-term care facilities where staff and residents alike make few of their own decisions, and where the persons being served may be viewed by some as disposable, non humans, their domination by the elites is assured. While this may be an

accurate reflection of societal attitudes about the elderly population described earlier, social workers who adhere to the Code (1994) must again advance its principle of the primacy of client dignity as we did in our work with other populations. In a context where compliance, routine and obedience dominate, social workers who believe in the Code of Ethics and work for change with our colleagues have the capacity to make a crucial difference.

Limitations

Some important trends were found in this exploratory study that support the hypothesis; these trends suggested similar decision-making power differences at each dyadic unit level. Although these trends were not statistically significant, there was a clear direction. It is likely that the effect size is not evident because the sample size was quite small. Nevertheless, the similarities in non significant trends certainly strikes a new path for future research focused on decision-making power in several long term care facilities where a larger sample size would be possible.

There are five main areas of limitation in this study. First there are some gaps in the available data. Most responses pertain to respondents' perceptions about decision making rather than to actual decisions made. Resident data were further limited in two ways. Residents did not complete all the instruments; and the residents of only one special care unit were available for observation.

Observed residents represented only a small number of the overall residents and they were qualitatively quite different in terms of decision making than were

those residents who responded to the questionnaire. While this may create some bias, alternatively, these two groups may be similar to other groups of residents in the home. While this prevents precise comparisons, nevertheless, qualitative data triangulates the quantitative data collected and extends my capacity to extrapolate on meanings of excluded resident data. Since the research focused on the differences and similarities between dyadic units, these limitations have meant that comparisons cannot be as strongly stated as they might otherwise have been. Because most workers float from one unit to another and from one shift to another depending on the need, the staff who work on a particular unit or with a particular resident varies. Therefore, while the residents are different, there will be similarities in the care they receive and in the decisions they are permitted to make.

The second area of limitation is the skewed nature of some of the data. For example, while most providers in this home were of the dominant ethnic group, this might not be the case in a region where the population was more diverse. The income data were flawed because the question was insufficiently constructed. Some of the counting questions resulted in skewed data due to individual interpretation by respondents. In addition, the lack of normal distribution of the organization subscales meant that the organizational questions could not be integrated into the study as well as might otherwise have been. Nevertheless, this particular limitation is constricted by the fact that the overall scale does reflect those organizational factors in addition to the care items. In

this way, the organizational data were available.

The third limitation arises from the attitudes, particularly fear, of direct care worker, leader and resident respondents. This was a difficult setting in which to gather these data. Many potential respondents were hesitant to complete the informed consent. While they did understand the questionnaire and the process and in some cases actually expressed the desire to participate, they were concerned about signing their name to anything and expressed fear of reprisal should the information be linked back to themselves. Other staff members expressed concern that since the study was approved by their employer, there might be a negative consequence for workers in the end. They spoke about the cuts in service and funding that impacted on them on a daily basis in their jobs and wondered if the study was part of an initiative to justify further cuts. Some of the members of these groups of clients and workers are vulnerable and regardless of the difficulty posed by involving vulnerable groups in study, they can benefit greatly from the result of research that uses their data gathered respectfully.

Finally, while these results cannot be completely generalized to other facilities, we do know that all long-term care facilities come under the same legislation and policy and compliance standards. While each region applies these standards somewhat differently and each CEO defines decision making from their own perspective, this limitation is somewhat compensated for by the reputation for excellence in long-term care held by both the region and this

particular CEO. During the course of the research, I met with the CEO on several occasions and can verify that during each meeting, s/he spoke passionately about the needs of residents and the commitment of the organization to provide good care. So, while the results cannot be generalized results may be to some extent representative of other such facilities.

While this was a complex project, and there is much work that can still be done both with these data and as other research projects are taken on, an attempt must be made by social workers to analyse the complexity of organizations using our knowledge about workers, clients, systems and power (Sarri & Hasenfeld, 1978). While there are many similarities between the power dynamics at the three levels, their intertwined nature makes analysis and understanding them difficult and challenging.

VIII: Conclusion

Decision making is central in lives of older adults as they determine where they shall live, how they will get the care they may need, and how they can spend their remaining time with as much pleasure and contentment as possible. But as elders seek self-determination and contentment, other members of society worry about the development of the advanced directives that will guide professional interventions, the safety and possible institutionalization of older adults, perhaps the control/restraint of what is defined as inappropriate behaviours by the elderly residents, and finally, the high costs of care. In this system, the decisions made by the Ministry of Health's long-term care division, its agencies and physicians, are the building blocks for care outcomes, individual decision based relationships — and costs. And in this system social workers are not idle bystanders; we often define the clients who get the service and the service they get (Regehr and Antle, 1997).

The Past

Despite the disadvantage that exists in organizations, questions of power have often been addressed by organizational theorists in relation to the organization's interest, rather than in the disadvantaged person's interest; yet, those individuals are disadvantaged in the interest of the organization (Mills & Simmons, 1999). "Power, social status, income and wealth are often gained in and through organizations, and so is disadvantage. Those whose relationship to modern organization is tenuous, disrupted, undeveloped or terminal, find

themselves labelled as somehow less than whole persons" (Mills & Simmons, 1999, p. 97). These dynamics are exemplified here.

A clue to these power relationships is displayed in the levels of dependency and powerlessness held by recipients of long-term care and the levels of authority and independent decision making held by health-care provider agencies. Hospitals and community home care teams have more power than those in long-term care facilities — hospitals because of their scientific and technological base, and community health-care organizations because they serve individuals who are more well functioning. More powerful organizations refer less desirable, frail elders on the edge of cognitive impairment to less powerful organizations — long-term care facilities, the last stop in life for many (Hasenfeld, 1983). As clients move from full independence, to dependence, to the "special" care that we offer to those who are most impaired, they lose decision-making capacity and power. And the organizations and individuals who are asked to care for them, to control their behaviours, are similarly disadvantaged over those organizations and individuals who care for well functioning persons (Hasenfeld, 1983). In many cases, workers and clients alike assume a feminized (Ferguson, 1984) stance of passivity.

When we move elders into institutions we translate their difficult reality into something compatible with our society's structure (De Montigny, 1995) and in so doing, we label, define and control great numbers of older adults. Clients of long-term care systems have little or no voice; their dependency, compliance

and trust of helpers further increases their vulnerability.

Although the power held by the provincial long-term care infrastructure was not directly studied, its influence was felt and discussed throughout. The bureaucracy defines the conditions by which one entity imposes its preference on another, through its standards and policies. While the system does have elements of meritocracy, cost cutting, and its namesake, efficiency, have led to a management system with few decisions made by the many, and more routinization and control by the few (Daft, 1998). This long-term health care system is able to meet its efficiency goals while appearing accountable, rational and neutral — and it disadvantages people along the way.

The documentation and routinization which exist to ensure quality care actually renders the opposite. In fact, the better staff are at routinization, documentation and meeting standards of compliance, the less time they have to deliver compassionate care (Foner, 1995). And, as workers obey the rules that originate higher in the hierarchy, the power of their manager, and ultimately the bureaucrat, is also enhanced, and the sense of control by female workers diminished (Ross & Wright, 1998). In a context of unpredictability, caused in part by unrealistic expectations for cost containment and also by the cognitive levels of residents, this undercurrent toward routinization and rationality increases. When efforts to control are somewhat successful in containing uncertainty, those in power continue to gain power-over the other and demand compliance. The cycle of diminishing decision making and escalating power in

the hands of the few completes its rotation.

In this study, leaders felt little decision-making power, seeing themselves as little more than puppets to the hand of the reigning bureaucrats. Direct care workers did not like their jobs, but when expected to cover for absent co-workers, they played a part in containing costs and compromising service. Some workers who were committed to a level of compassionate care but were also unable, perhaps, to find a way to do what was right chose to leave direct care. But when they remained, it was these direct care workers who taught residents to comply. At its worst, care was controlled by an ordered, mechanical, unemotional power. Residents, unable to seize the self-determination they craved, often passively accepted what was offered — signaling the power of providers as they complied. Those less connected with life had less power; and the power of the bureaucrat, was for the most part, invisible.

The Place of this Study

There have been few, if any, studies particular to long-term care that simultaneously consider decision making at both care and organizational levels. The goal was to gain understanding of relationships between organizational and personal power and levels of dependence, autonomy and personal power held by residents. While Kruzich (1995) looked at the influence of organization characteristics on decision making, this study has focused more on the characteristics of, and dynamics between people.

Decision-making power, or more precisely its absence, seems to flow through the organization along paths similar to those defined by power theorists. Workers and residents, primarily women, work in a system defined by the care it gives and the marginalized population it serves. The marginalization radiates through hierarchical levels marked by gender, age, differential incomes, number of decisions, importance of decisions (and care scores particularly related to care). Many direct care workers (41%) and leaders (36%) also work part-time. Shapiro and Havens point to the increasing tendency to use part-time workers "particularly in the service sector" as a way for employers to avoid benefits and pension, a process that further marginalizes these workers (Shapiro & Havens, 2000). Managers have more decision-making power than leaders; leaders have more decision-making power than workers; and, workers have more decision-making power than residents. The work of those at lower levels is defined by the level of impairment of care recipients and the need and demand for care that accompanies that impairment (Hugman, 1991). Perhaps here, a push for homogeneity (Ferguson, 1984) comes from the shared feelings of powerlessness in decision making.

Downward interlocking spirals of decision making and organizational power are held together by similarities of gender, decision-making responses and by the capacity to define one's decision-making power when one knows the individual's view of supervisor's decision-making power. These findings are bolstered by the defined differences between care providers and non-care

providers; this contrast offers credence to the argument that it is the care giving and the population served that spell out the differential power and decision-making dynamics. Just as the decision-making power of the resident is constrained by the direct care worker, the decision-making power of the worker is constrained by their supervisor, and finally the supervisors' decision-making power is constrained by the Minister of Health.

Power flows from science, technology and from life itself. The powerful are different from the powerless demographically, financially and in terms of decision-making power. In this setting where the care is too often only custodial, there is little support for science or technology. Care providers are older female workers with little education; recipients of care are primarily old women, approaching death. In this system of care, power originates off site, in regional and provincial bureaucracies. The bureaucratic system of rules, hierarchy, rationality and order, initially defined by Weber (1947) still applies in Ontario's long-term care system in 2002.

Finally, chaos theory informs both bureaucracy and the dynamics of power that accompany it. Chaos, when applied to organizations is all about power and its distribution; a chaotic organization would be less hierarchical, less linear, not controllable and creative. Loops of information and knowledge would provide continuous feedback in a process of on-going change. The complexity of chaos, inherent in human systems and evident in this long-term care facility remains regardless of bureaucratic and management attempts to impose control. What

seemed initially to be parallel but linear, replications of power, in each dyadic unit studied, were more chaotic and complex than originally conceived. Complex, fractal-like patterns of decision-making did emerge, converging parallel spirals of restrained decision-making power. The lens of chaos encourages new ideas for the future in long-term care.

The Future

This study has taken place in a world obsessed with control and dominated by cognition. Humans seek to control life, to maximize and to exploit, ultimately searching for power over our environment and its resources. Seeking the perfect tomato, the fastest car, the best education, the smartest child, we overuse and exploit the world's resources and its vulnerable people in the process. One of the most effective instruments in the pursuit is organizational power — whether in the street gang, in the large corporation, or in a bureaucratic long-term care health organization.

Yet the very nature of humanity is chaotic, not unlike that described by Prigogine and Stengers (1984) in their essential work on chaos theory. There is a fundamental contradiction between what it means to be human — that is to live in chaos — and our tendency to control and dominate. Are we trying to compensate for one of our most basic characteristics? Nowhere are people more apt to display their chaotic nature than in institutions inhabited by people who can no longer control their lives, their decisions or their bodies. But it is here that we can see some of the most heavy-handed efforts to control the behaviours

that are, perhaps, an embarrassment to our vision of ourselves as a scientific, technologically advanced society.

To move beyond these embedded differential bases of power, second order change is needed, a change that will push the boundaries (Harlos, 1995; Martin, Harrison, & Dinitto, 1983). When today's workers push elders toward passivity and compliance, an inclination that carries both high financial and personal costs, they themselves are also facing a similar demand from their supervisors, and their supervisors are experiencing a similar demand from their supervisors, and on up the line. Everyone is being asked to comply. Everyone is being asked to restrain their personal decision-making power. If instead they were encouraged to participate in decision making, staff and resident morale would perhaps be enhanced, people could feel their views were valued and workers might decide to deliver the care they know is possible, and would likely stay longer. When freed of restraints, competence may flourish.

As we face this new century, disorder, unpredictability and nonlinear relationships are embedded in our world. As a species we both create and exist in a state of disequilibrium and unpredictability — chaos. Where fast-paced change, technological advances, and proliferation of information are the norms, pressure on the health-care system is being exerted by increasing numbers of old people and declining government dollars; and the old version of strategic planning and traditional hierarchy is not working. Health care is reaching the boiling point. In spite of our attempt to control everything from life forms to

space travel, unpredictability remains (Tarnas, 1991).

This theory of chaos, while not a panacea, does illuminate the system. Workers and residents alike are caught in a system of restrained power and cynicism where trained nurses prefer to clean floors, residents fear they will be left without clothing while staff take coffee breaks and managers speak of a system "out of control" (Informant B). Power-over both worker and client by the organization could be replaced by power-with, a sharing of power between equals (Hugman, 1991; Harlos, 1995). Chaos thinking allows us to acknowledge the fundamental nature of humans and look beyond and through the boundary that exists between the control we have preferred and the creativity that exists beyond the bifurcation point, at "the edge of chaos" (Prigogine & Stengers, 1984; Zimmerman, 1996, p.3).

Just as the machine metaphor no longer applies to a world of technology, the principles of bureaucracy must either be adapted or given up altogether to allow creativity to flourish. Nowhere is this more justified than in a world where creativity is one of a handful of tools available to help individuals who have lost all personal control and rationality. Chaos encourages the both/and thinking that will be useful where we need control along with compassionate care. The creativity that arises from chaos may stimulate excellence in the work of care givers, and lead to the thinking that will encourage more independent choice by even impaired older adults. "Maximizing control for even impaired older adults could mean more apparent chaos, but with a confidence in the

fractals, may lead to an inherent order" (Fusco, personal communication, 2002).

Rather than using our training and legitimate power to overpower another, we might instead consider what decisions can be made by the elder, even the cognitively impaired elder. But to do this, we must put aside our passion for total control and our belief that we know better. As Genvay warns "letting go of control brings better results, but it is very very hard to do" (Genvay, 1994, p.14). Perhaps we can then meld the best of science, technology and rationality, with that of collectivity, caring and chaos. If we can "bring[ing] the margin to the centre"(Harlos, 1995, p.22), construct a care culture that builds power and supports people, we might be closer to the effective service we seek.

The basic safety and well being of persons who cannot care for themselves will likely always require some control. While the balance is currently skewed in favour of the powerful, those most vulnerable recipients of care, cognitively impaired individuals, do require protection along with the compassion. Professionals who understand empowerment, marginalization and power can work with the elders themselves to meet both the need for control and for independence, and shift that balance in the process (Fusco, 1983). Can the long-term care client have decision-making power and control simultaneously with care?

While today's organizational language defines cost containment, rationality and the bottom line metaphors that denote rules, power and control,

social workers on the other hand, discuss and write about empowerment, advocacy, and autonomy. Perhaps we can lead the way to a vision of abundant power that can be shared, even with those most vulnerable among us, rather than a finite amount that must be protected (Harlos, 1995). A new style of leader or multi-disciplinary team might share power and empower others rather than oppress them, building a culture of integrity, cooperation and concentric circles, where power is equal but differentiated (Daft, 1998; Harlos, 1995; Helgesen, 1990; Peters, 1987). In preparing for such a move, chaos theory offers ideas of renewal applicable as we emerge from a time of change and flux (Gleick, 1987; Tetenbaum, 1998; Zimmerman, 1994). Perhaps, like Lorenz' butterfly effect, social workers can begin by defining a context of mutuality, care and equality where impaired elders are respected for the decisions they still can make. Even if such a change occurred in one small area or relationship within the home, such a small change could be the catalyst, the butterfly wing that begins a transformative shift in the whole.

Future Research

New questions about power, decision making, and teamwork emerge from this study. Central among them is a question about the relationship of management and ownership to decision-making power. Management styles have a significant local impact on decision making; it would be useful to compare management styles in for-profit and not-for-profit institutions while simultaneously comparing resident and staff decision patterns. Similarly, it

would be helpful to compare these results to results that might emerge from a similar study in a community based health-care program, and a hospital based health-care program. In addition to exploring the impact on decision making by the mandate of the organization, this would also allow an exploration of the influence of other structural factors (Kruzich, 1995).

The significant difference between direct care staff and non-direct care staff suggests a comparison of decision-making power dynamics that exist in a social service agency that serves vulnerable persons, but without the direct physical care. If the dichotomy described between the structures of bureaucracy structures and the fluidity of chaos hold fast, similar results may also emerge where there is marginalization without hands-on care.

This small study of one organization has raised many questions. Would a change in the power structures between the CEO and manager have an effect on those in the system who are dealing with felt powerlessness? When clients are passive, do they receive better or worse care? Does an affiliation with professional colleges and associations, themselves sources of power, change the worker's use of power in their work? What is the role of the researcher in the power balance in the home and does chaos offer any help in redefining researcher power?

Long-term care programs rely on the expenditure of bureaucratic, centrally controlled resources. When the people needing help are old, female, impaired and close to death and the workers providing the care are middle-aged,

female, with few job options, the government of the day has the tools it needs to impose control. Citizens and the professionals who implement their directives are at least partly responsible for putting the tools in their hands. But if instead, power is downloaded to the workers on the ground, a new energy and care system may emerge.

Appendices

Appendix A: Ethics Approval Letter

Wilfrid Laurier University

Founded 1911

December 13, 2000

Sandra Loucks Campbell
Faculty of Social Work
Wilfrid Laurier University

Dear Ms. Campbell:

Re: Your Research Proposal Entitled, "The Dynamics of Personal Decision Making in a Home for the Aged"

The Research Ethics Board of Wilfrid Laurier University has reviewed the above proposal and determined that the proposal is ethically sound.

If the research plan and methods should change in a way that may bring into question the project's adherence to acceptable ethical norms, please contact me as soon as possible and before the changes are put into place.

Upon completion of your research project, you must submit a final report. You can use the "Final Report on Graduate Student Projects", found on the Research Office web site (http://www.wlu.ca/~wwwroff/ethics.html), as a template.

Yours sincerely,

Bruce Arai, PhD
Chair, WLU Research Ethics Board

BA/jb

Appendix B: Information Letter(Original Wilfrid Laurier University letterhead)

You are invited to participate in a research study being conducted at (named) Home for the Aged. The purpose of the project is to study the processes of personal decision making by staff and residents in long term care.

The study will be conducted by Sandra Loucks Campbell as a part of her work as a PhD student at Wilfrid Laurier University. Sandra is a social worker who has worked with older adults and their caregivers for 25 years in a variety of settings. You can contact the researcher at her home at 519-885-3016, or by asking for an appointment with her through administrative assistant (named) to the home administrator (named). Details about the research study will also be provided during presentations at meetings with staff and/or management at the Home.

Staff participants will be asked to complete a questionnaire that will take about 30–45 minutes. Permission has been given for staff to complete the questionnaire during the participant's normal shift of work. The researcher will assist residents in the completion of a similar questionnaire.

The researcher, and one other person, will act as observer during the participant observation phase of data collection in the public rooms of selected secure units on several occasions, for approximately 3 hours each visit. She will not approach residents nor staff during that time.

The confidentiality of all identifying or personal material will be protected at all stages of the project. Data from individuals will not be shared inside or outside of the facility except as grouped aggregate data.

This study will help to enhance understanding about decision making in long term care. This enhanced understanding of decision making has the potential to identify decision processes that are positive and thereby enhance resident well being, satisfaction and mortality rates, and also enhance staff morale and decrease the rates of turnover in this facility. The study also builds a foundation on which similar studies may be conducted in other facilities.

Please consider participating in the study. Thank you.

Sincerely,

Sandra L. Campbell M.S.W., Gr. Dip. (Admin)

Appendix C: Informed Consent Documents
(Originals on Wilfrid Laurier University letterhead)
WILFRID LAURIER UNIVERSITY
INFORMED CONSENT STATEMENT
for proxy decision makers for residents of secure units
The dynamics of personal decision making in a Home for the Aged
Sandra Loucks Campbell 519-885-3016

You are invited to permit the resident of the Home for whom you are the substitute decision maker to participate in a research study. The purpose of this study is better understand personal decision making in a Home for the Aged.

INFORMATION
The researcher will observe residents in the public areas of secure units and count and record decision making behaviours of residents in those areas. The researcher and one assistant will observe the residents in those public areas on 3-5 occasions for about 3 hours each visit. The researcher will take notes, but will not approach residents. There is no deception in this study.

Substitute decision makers of each resident in the selected secure units participating in the study will have information about the study and will have the right to decline from participation or withdraw their family member at any time during the study. All personal or identifying information will be protected. Substitute decision makers will have the opportunity to review a summary of the final report as requested and a copy of the summary will be posted in the Home for the Aged.

RISKS
Concern may be experienced by proxy decision makers that elders will be upset by the presence of researchers. Participants or proxy decision makers are invited to call the researcher, Sandra L.Campbell, at 519-885-3016, if they have any questions or concerns about the observation. If an elder becomes upset, the researcher will remain with the elder until they are calm and will consult one of their main caregivers, such as the duty nurse or the staff social worker. Emotional support will be provided.

BENEFITS
This study will help to enhance understanding about decision making in long term care. This enhanced understanding of decision making has the potential to identify decision processes that are positive and thereby enhance resident well being, satisfaction and decrease mortality rates, and also enhance staff morale and decrease the rates of turnover in this facility. The study also builds a foundation on which similar studies may be conducted in other facilities.

CONFIDENTIALITY

All personal or identifying information will be protected at each step in the research project. Any such information will not be shared inside or outside the facility except as grouped data. The names of participants and of the Home for the Aged itself will not be shared. Aggregate or grouped data will be analysed only as grouped data and will be the base of presentations and articles in academic journals or text books only in grouped forms. Raw data and computer storage of the data will be locked up in the researcher's private home file cabinet.

COMPENSATION

There is no compensation for participating in the study.

CONTACT

If you have questions at any time about the study or the procedures, (or you expect or observe adverse effects as a result of your loved one's participation in this study) please contact the researcher,Sandra L. Campbell, at 140 MacKay Crescent, Waterloo, and 519-885-3016. If you feel your loved one has not been treated according to the descriptions in this form, or their rights as a participant in research have been violated during the course of this project, you may contact Dr. Linda Parker, Assistant Dean, Graduate Studies and Research at Phone 884-0710 extension 3126 or the project supervisor, Dr. Martha Laurence, Faculty of Social Work, Wilfrid Laurier University, 519-884-1970.

PARTICIPATION

Your permission to have your loved one participate in this study is voluntary; you may, on their behalf, withdraw their participation in the study without penalty. If they withdraw from the study before data collection is complete, any data that is linked to the elder for whom you make decisions will be destroyed.

CONSENT

I have read and understand the above information. I have received a copy of this form.

I agree to _____'s (resident's name) participation in this study.

Substitute decision maker's signature_____ Date_____
Substitute decision maker's signature_____ Date_____
Investigator's signature_____ Date_____

WILFRID LAURIER UNIVERSITY
INFORMED CONSENT STATEMENT
for staff, managers and participating residents
The dynamics of personal decision making in a Home for the Aged
Sandra L. Campbell 519-885-3016

You are invited to participate in a research study. The purpose of this study is better understand personal decision making in a Home for the Aged.

INFORMATION
The researcher will be distributing questionnaires to staff, managers and residents at the Home for the Aged. Each person is invited to complete the questionnaire; they will take about 30-45 minutes to complete. There is no deception in this study. Each person participating in the study will have information about the study and will have the right to decline participation or withdraw at any time during the study. All personal or identifying information will be protected. Participants will have the opportunity to review a summary of the final report as requested and a copy of the summary will be posted in the Home for the Aged.

RISKS
Concern may be experienced that elders will be upset or confused by the questions about decision making. Participants or proxy decision makers are invited to call the researcher, Sandra L. Campbell, at 519-885-3016, if they have any questions or concerns about the study or the questionnaire. If an elder becomes upset, the researcher will remain with the elder until they are calm and will consult one of their main caregivers, such as the duty nurse or the staff social worker. Emotional support will be provided.

BENEFITS
This study will help to enhance understanding about decision making in long term care. This enhanced understanding of decision making has the potential to identify decision processes that are positive and thereby enhance resident well being, satisfaction and decrease mortality rates, and also enhance staff morale and decrease the rates of turnover in this facility. The study also builds a foundation on which similar studies may be conducted in other facilities.

CONFIDENTIALITY
All personal or identifying information will be protected at each step in the research project. Any such information will not be shared inside or outside the facility except as grouped data. The names of participants or of the Home for

the Aged itself will not be shared. Aggregate or grouped data will be analysed only as grouped data and will be the base of presentations and articles in academic journals or text books only in grouped forms.

Staff may be concerned that results will be shared within the facility thereby compromising their internal relationships. No identifying material will be shared inside or outside the facility. The only information that will be shared will be in aggregate form. The confidentiality of the material collected will be protected at each step in the process. Raw data and computer storage of the data will be locked up in the researcher's private home file cabinet.

COMPENSATION

There is no compensation for participating in the study.

CONTACT

If you have questions at any time about the study or the procedures, (or you experience adverse effects a result of participating in this study) please contact the researcher, Sandra L. Campbell, at 140 MacKay Crescent, Waterloo, and 519-885-3016. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Linda Parker, Assistant Dean, Graduate Studies and Research at Phone 884-0710 extension 3126 or the project supervisor, Dr. Martha Laurence, Faculty of Social Work, Wilfrid Laurier University, 519-884-1970.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you withdraw from the study before data collection is complete, any data that is linked to you will be returned to you or destroyed.

CONSENT

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature_____ Date_____
Participant's signature_____ Date_____

Investigator's signature_____ Date_____

Appendix D: Instrumentation

Resident Questionnaire

Resident Questionnaire. (Administrated by Principal Investigator)

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
1. In general, how much say do others have in placing restrictions on your activity level?	1	2	3	4	5
2. In general, how much say do others have in getting your medication order changed?	1	2	3	4	5
3. In general, how much say do others have in deciding whether you get transferred into or out of the facility (unit)?	1	2	3	4	5
4. In general, how much say do others have in making changes in your care plan?	1	2	3	4	5
5. In general, how much say do others have in planning your general care?	1	2	3	4	5
6. In general, how much say do others have in deciding whether you can attend activity therapy?	1	2	3	4	5
7. In general, how much say do others have in choosing your type of therapeutic activities?	1	2	3	4	5
8. In general, how much say do others have in choosing your type of recreational activities?	1	2	3	4	5
9. In general, how much say do others have in whether you are allowed snacks during the day?	1	2	3	4	5
10. In general, how much say do others have in how often you get either a shower or a tub bath?	1	2	3	4	5

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
11. In general, how much say do others have about when you are to get up in the morning?	1	2	3	4	5
12. In general, how much say do others have in deciding when you go to bed at night?	1	2	3	4	5
13. In general, how much say do others have in deciding your toileting schedule?	1	2	3	4	5
14. In general, how much say do others have about your clothing choices?	1	2	3	4	5
15. In general, how much say do others have about your food selection?	1	2	3	4	5
16. In general, how much say do others have about when you wash, shave, brush your teeth and comb your hair?	1	2	3	4	5
17. In general, how much say do others have about when you may use your sleeping quarters to take a nap?	1	2	3	4	5
18. In general, how much say do others have in planning special activities for you? (e.g., Christmas parties or other celebrations)	1	2	3	4	5
19. In general, how much say do others have in deciding your general daily routine?	1	2	3	4	5

20. Other than yourself, who makes decisions that affect you? (Not names but positions)

_____

_____

21 Do you have any other comments?

_____

_____

_____

Background Information:
This section of the questionnaire includes some background questions about you.

Background Information:
This section of the questionnaire includes some background questions about you.

22 What is your gender? _____Male _____ Female

23 How old are you? _____ years

24 Would you consider yourself part of an ethnic minority? Yes No

25 If yes, what minority?_____

26 In which of the following categories does your annual income fall?
$0 - $12,000
$12,001 - $20,000
$20,001 - $35,000
$35,001 - $45,000
Over $45,000

27 How many years of education do you have? _____ (total number of years overall)

28 How many months have you been living in this Home for the Aged? _____ (total number of months)

29 What unit do you live on? _____

Thank you for your help with this study.

Staff Questionnaire

An important aspect of any job is an individual's perception of their influence in various areas of their work. This questionnaire asks you to identify your level of involvement in different activities that take place in the long term care facility (or in the unit).

Please circle, for each of the items listed below, the level of influence you have in each of the areas listed.

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
1. In general, how much say do you have in placing restrictions on a resident's activity level?	1	2	3	4	5
2. In general, how much say do you have in getting a resident's medication order changed?	1	2	3	4	5
3. In general, how much say do you have in deciding who gets transferred into or out of the facility (unit)?	1	2	3	4	5
4. In general, how much say do you have in making changes in the care plan?	1	2	3	4	5
5. In general, how much say do you have in planning residents' general care?	1	2	3	4	5
6. In general, how much say do you have in deciding whether residents can attend activity therapy?	1	2	3	4	5
7. In general, how much say do you have in choosing a resident's type of therapeutic activities?	1	2	3	4	5

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
8. In general, how much say do you have in choosing a resident's type of recreational activities?	1	2	3	4	5
9. In general, how much say do you have in whether residents are allowed snacks during the day?	1	2	3	4	5
10. In general, how much say do you have in how often residents get either a shower or a tub bath?	1	2	3	4	5
11. In general, how much say do you have about when residents are to get up in the morning?	1	2	3	4	5
12. In general, how much say do you have in deciding when residents go to bed at night?	1	2	3	4	5
13. In general, how much say do you have in deciding the toileting schedule of residents?	1	2	3	4	5
14. In general, how much say do you have about the residents' clothing choices?	1	2	3	4	5
15. In general, how much say do you have about the food selection for specific residents?	1	2	3	4	5
16. In general, how much say do you have about when the residents wash, shave, brush their teeth and comb their hair?	1	2	3	4	5

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
17. In general, how much say do you have about when residents may use their sleeping quarters to take a nap?	1	2	3	4	5
18. In general, how much say do you have in planning special activities for residents? (e.g., Christmas parties or other celebrations)	1	2	3	4	5
19. In general, how much say do you have in deciding the general daily routine of the residents?	1	2	3	4	5

20. In relation to the first 19 questions, who has more say than you do? (Not names but positions)_____

_____

_____

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
21. In general, how much say do you have in deciding how the duties of the staff are divided up each day?	1	2	3	4	5
22. In general, how much say do you have in getting someone who does poor work fired?	1	2	3	4	5

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
23. In general, how much say do you have in getting problems of absenteeism corrected?	1	2	3	4	5
24. In general, how much say do you have in getting yourself a job transfer if desired?	1	2	3	4	5
25. In general, how much say do you have in deciding how a unit is to be decorated? (e.g., paint colours, pictures, curtains, etc.)	1	2	3	4	5
26. In general, how much say do you have in settling differences of opinion among staff?	1	2	3	4	5
27. In general, how much say do you have in deciding staff work schedules (which days and hours)?	1	2	3	4	5
28. In general, how much say do you have in deciding when breaks are to be taken?	1	2	3	4	5
29. In general, how much say do you have in what your specific tasks for each day are to be?	1	2	3	4	5
30. In general, how much say do you have in deciding whether your quality of work merits a raise in pay?	1	2	3	4	5

31. In regard to the previous questions, 21 to 30, who has more influence than you? (Not names, but positions)

_____

_____

_____

	Very dissatisfied	A little dissatisfied	Neutral	A little satisfied	Very satisfied
32. How satisfied are you in general with the amount of your personal involvement in decision making at the facility where you work?	1	2	3	4	5

	Poor cooperation	Fairly satisfactory cooperation	Good cooperation	Very good cooperation	Excellent cooperation
33. How well do people from the various departments generally cooperate with each other in providing patient care?	1	2	3	4	5

	Never important	Usually not important	Sometimes important, sometimes not important	Usually important	Always important
34. How many decisions do you make about residents on your own in an average week? Please estimate the number_____.					
→ Rate the importance of those decisions	1	2	3	4	5

	Never important	Usually not important	Sometimes important, sometimes not important	Usually important	Always important
35. How many decisions do you make about staff on your own in an average week? Please estimate the number_____. → Rate the importance of those decisions	1	2	3	4	5
36. How many decisions do you make about your own daily schedule and work, on your own, in an average week? Please estimate the number_____. → Rate the importance of those decisions	1	2	3	4	5

37. Please elaborate.

_____

_____

_____

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
38. How would you rate yourself on having influence on decision making in this organization?	1	2	3	4	5
39. How do you think others would rate you?	1	2	3	4	5

	Do not use it	Use it less than once per month	Use it weekly	Use it daily	Use it all the time
40. How would you rate yourself in your use of the organization philosophy in your decision making?	1	2	3	4	5

41. Can you give one or two examples?

_____

_____

_____

_____

	Do not use it	Use it less than once per month	Use it weekly	Use it daily	Use it all the time
42. How would you rate others in their use of the organization philosophy in their decision making?	1	2	3	4	5

43. Can you give one or two examples?

_____

_____

_____

Questions 44 – 75:

Identify someone in a position above you (for example, at the level of your supervisor or higher) in the organization. Picturing *that person* and thinking about how she/he does their job, answer the following questions (44-75) as you think *that person* would answer the same questions.

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
44. In general, how much say does *that person* have in placing restrictions on a resident's activity level?	1	2	3	4	5
45. In general, how much say does *that person* have in getting a resident's medication order changed?	1	2	3	4	5
46. In general, how much say does *that person* have in deciding who gets transferred into or out of the facility (of the unit)?	1	2	3	4	5
47. In general, how much say does *that person* have in making changes in the care plan?	1	2	3	4	5
48. In general, how much say does *that person* have in planning residents' general care?	1	2	3	4	5
49. In general, how much say does *that person* have in deciding whether residents can attend activity therapy?	1	2	3	4	5
50. In general, how much say does *that person* have in choosing a resident's type of therapeutic activities?	1	2	3	4	5
51. In general, how much say does *that person* have in choosing a resident's type of recreational activities?	1	2	3	4	5

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
52. In general, how much say does *that person* have in whether residents are allowed snacks during the day?	1	2	3	4	5
53. In general, how much say does *that person* have in how often residents get either a shower or a tub bath?	1	2	3	4	5
54. In general, how much say does *that person* have about when residents are to get up in the morning?	1	2	3	4	5
55. In general, how much say does *that person* have in deciding when residents go to bed at night?	1	2	3	4	5
56. In general, how much say does *that person* have about when residents may use their sleeping quarters to take a nap?	1	2	3	4	5
57. In general, how much say does *that person* have in planning special activities for residents? (e.g., Christmas parties or other celebrations)	1	2	3	4	5
58. In general, how much say does *that person* have in deciding the general daily routine of the residents?	1	2	3	4	5
59. In general, how much say does *that person* have in deciding how the duties of the staff are divided up each day?	1	2	3	4	5
60. In general, how much say does *that person* have in getting someone who does poor work fired?	1	2	3	4	5

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
61. In general, how much say does *that person* have in getting problems of absenteeism corrected?	1	2	3	4	5
62. In general, how much say does *that person* have in getting themself a job transfer if desired?	1	2	3	4	5
63. In general, how much say does *that person* have in deciding how a unit is to be decorated? (e.g., paint colours, pictures, curtains, etc.)	1	2	3	4	5
64. In general, how much say does *that person* have in settling differences of opinion among staff?	1	2	3	4	5
65. In general, how much say does *that person* have in deciding staff work schedules (which days and hours)?	1	2	3	4	5
66. In general, how much say does *that person* have in deciding when breaks are to be taken?	1	2	3	4	5
67. In general, how much say does *that person* have in what their specific tasks for each day are to be?	1	2	3	4	5
68. In general, how much say does *that person* have in deciding whether your quality of work merits a raise in pay?	1	2	3	4	5

Please also answer the following questions also as you believe *that person* above you in the organization would answer them.

	Very dissatisfied	A little dissatisfied	Neutral	A little satisfied	Very satisfied
69. How satisfied do you think *that person* is in general with the amount of their personal involvement in decision making at the facility where you work?	1	2	3	4	5

	Poor cooperation	Fairly satisfactory cooperation	Good cooperation	Very good cooperation	Excellent cooperation
70. How well does *that person* think people from the various departments generally cooperate with each other in providing patient care?	1	2	3	4	5

	Never important	Usually not important	Sometimes important, sometimes not important	Usually important	Always important
71. How many decisions does *that person* believe they make about residents on their own in an average week?					
Please estimate the number_____.					
→ Rate the importance of those decisions	1	2	3	4	5

	Never important	Usually not important	Sometimes important, sometimes not important	Usually important	Always important
72. How many decisions does *that person* believe they make about staff on their own in an average week? Please estimate the number_____. → Rate the importance of those decisions	1	2	3	4	5
73. How many decisions does *that person* make about their own daily schedule and work on their own in an average week? Please estimate the number_____. → Rate the importance of those decisions	1	2	3	4	5

	No influence	A little influence	Some influence	Quite a bit of influence	A great deal of influence
74. How would *that person* rate themself on having influence on decision making in this organization?	1	2	3	4	5
75. How do you think others would rate them?	1	2	3	4	5

Please answer the remaining questions about <u>YOURSELF ONLY</u>.

76. Approximately how many people are dependent on *your* decisions in order to do their jobs? Number_____.

77. What words come to mind when you think about the decisions *you make* on the job?_____
_____
_____

<u>Background Information:</u>
This section of the questionnaire includes some background questions about you.

78. What is your gender? _____Male _____ Female

79. How old are you? _____ years

80. Would you consider yourself part of an ethnic minority? Yes No

81. If yes, what minority?_____

82. In which of the following categories does your annual income fall?
    $0 - $12,000
    $12,001 - $20,000
    $20,001 - $35,000
    $35,001 - $45,000
    Over $45,000

83. How many years of education do you have? _____ (total number of years overall)

84. How many months have you been working with this Home for the Aged? _____
    (total number of months)

85. What is the name and/or number of the unit where you usually work? _____

86. What schedule do you usually work?

Full time Part Time Casual Temporary

87. What shift do you work the most often?

Days Afternoons Nights Weekends

88. What is your role at Linhaven? (Please circle the category or categories that best define your role at Linhaven.)

Direct Patient Care (Job Categories)

Senior manager Middle Manager Registered Nurse

Non-registered nurse Other professional

Non-Direct Patient Care (Job Categories)

Senior manager Middle Manager Worker

89. To assist me in knowing what you do, please give me some words to clarify what you do.

_____

_____

_____

This completes the questionnaire. Thank you for your help.

Appendix E: Variables

Variables

Variables have been selected because of their relationship to decision-making and to organizational power, as identified in the literature review. Independent variables are those factors that may influence and cause changes in the dynamics of decision-making power shown in this home. The dependent variables include those aspects of actual or perceived decision-making that are measurable and applicable in this setting.

Independent Variables.

V1. Age in years (Continuous)
V2. Gender (M/F) (Categorical)
V3. Ethnicity (Categorical)
V4. Income in dollar categories (Categorical)
V5. Education in years (Continuous)
V6. Tenure in months (Continuous)
V7. Unit of Work (Categorical)
V8. Work Schedule (Categorical)
V9. Shift Worked (Categorical)
V10. Personnel/Resident Roles (Categorical)

Dependent Variables: (Continuous).

V11 = Staff Involvement in Decision Making (SIDM)
V12 = Care Subscale
V13 = Care Subscale with Four Added Items
V14 = Organization Subscale
V15 = Staff Involvement in Decision Making - Perception of Superior
V16 = Care Subscale - Perception of Superior
V17 = Organization Subscale -- Perception of Superior
V18 = Number of Decisions made in average week about residents
V19 = Perceived Importance of decisions made about residents
V20 = Number of Decisions made in average week about staff
V21 = Perceived Importance of decisions made about staff
V22 = Number of Decisions made in average week about self
V23 = Perceived Importance of decisions made about self
V24 = Perceived Scope of Decision Influence
V25 = Number of persons dependent on participant's decisions

V26 = Application of Philosophy in decisions by self
V27 = Perceived Application of Philosophy in decisions by others
V29 = Counted observed decision behaviours on secure units

Appendix F: Additional Tables

Table F1: Test of Normality

Tests of Normality

	Kolmogorov-Smirnov[a]		
	Statistic	df	Sig.
Age	.171	115	.000
Education	.071	111	.200*
Tenure	.197	115	.000
Decision Making Scale	.082	69	.200*
Decision Making Scale--Care Only	.071	107	.200*
DMSCare: added items	.070	107	.200*
Decision Making Scale Organization only	.153	73	.000
DMS -- Perception of Superior	.072	69	.200*
DMS Care -- Perception of Superior	.091	70	.200*
DMS Organization -- Perception of Superior	.108	71	.038

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Table F2: Correlations of Scales (Pearson)

Pearson Correlations

		SIDM(r)	Care/Added Items Subscale	SIDM -- Perception of Superior	Care Subscale -- Perception of Superior
SIDM(r)	Pearson Correlation				
	Sig. (2-tailed)				
	N				
Care/Added Items Subscale	Pearson Correlation	**			
	Sig. (2-tailed)				
	N				
SIDM -- Perception of Superior	Pearson Correlation	.404**	.492**		
	Sig. (2-tailed)	.001	.000		
	N	62	65		
Care Subscale -- Perception of Superior	Pearson Correlation	.420**	.620**	**	
	Sig. (2-tailed)	.001	.000		
	N	63	66		

**. Correlation is significant at the 0.01 level (2-tailed).

Table F3: Correlations of Scales with Individual Variables – All Staff Respondents (Rho)

Scales	Import. Decisions Residents	Import. Decisions Staff	Import Decision Self	Influence	Influence By Other	Philos. Use	Philos. Use By Others
SIDM (r)	.298*	.555**		.456** .355 (PS)**	.311*	.453**	.348**
Care Added Items Subscale		.322*		.238* .248 (PS)*		.300*	.312*
SIDM PS	.271 (PS)*		.283 (PS)*	.384 (PS)**	.410 (PS)**		
Care Subscale PS				.280 (PS)*			

**Correlation is significant at the .01 level.
* Correlation is significant at the .05 level.

Table F 4: Correlations for Perceived Importance of Decisions Regarding Residents, Staff and Self- All Staff Respondents (Rho)

	Import. Decisions Residents	Import. Decisions Staff	Import. Decisions Self	Influence	Influence Other	Philos. Use	Philos. Use Others	Age
Respondent: resident		.679** .286 (PS)*	.597** .270 (PS)*	.427**	.376**	.303*		-.260*
Respondent: staff	.679**		.549**	.457**	.338**	.473**		-.297*
Respondent: self	.597**	.549** .326 (PS)**		.302*	.367**	.350**		
PS resident		.617(PS)**	.707(PS)**				.336*	
PS staff	.286* .617 (PS)**		.326** .668 (PS)**		.251 (PS)*			
PS self	.270* .707 (PS)**		.688 (PS)**	.411 (PS)**	.426 (PS)**			

**Correlation is significant at the .01 level.
* Correlation is significant at the .05 level.

Table F5: Correlations for Perceived Influence: Self and by Others – All Staff Respondents (Rho)

	Import Decisions Resident	Import. Decisions Staff	Import. Decisions Self	Influence	Influence Others	Philos. Use	Education
Respondent: Influence	.427**	.457**	.302*	.235 (PS)*	.644**	.339**	.313**
Respondent: Influence Other	.376**	.338*	.367**	.644** .269 (PS)*		.276*	
PS Influence			.411(PS)**	.235*	.269* .687 (PS)**		
PS Influence Other		.251 (PS)*	.426(PS)**	.687 (PS)**			

**Correlation is significant at the .01 level.* Correlation is significant at the .05 level.

Table F6: Correlations for Use of Organizational Philosophy by Self, Others – All Staff Respondents (Rho)

	Import. Decisions Residents	Import. Decisions Staff	Import. Decisions Self	Influence	Influence Others	Philos. Use	Philos. Use Others
Philos. Use – self	.303*	.473**	.350**	.339**	.276*		.660**
Philos. Use– other	.336 (PS)*					.660**	

**Correlation is significant at the .01 level.* Correlation is significant at the .05 level.

Table F7: Individual Variable Correlations by Personnel Groups (rho)

Correlated Variables	Managers	Leaders	Direct Care Workers	Non-Direct Care Workers
SIDM Correlelates with				
Import. Decisions Residents				.841**
Import. Decision Staff		.707*		.912 **
Import. Decisions Self				.615 *
My influence		.602*	.471* .421 (PS)*	
My influence/others			.457*	
Philosophy use			.430*	
Philosophy use/others			.489*	
Care Subscale Correlates with				
Import. Decisions Residents				.603*
Import. Decision Staff	.578*			.728*
Import. Decisions Self	.586*			
My influence			.388* .508 (PS)**	
My influence/others			.410*	
Philosophy use				.634*
Philosophy use/others			.509*	
Tenure		.484*		
SIDM PS Correlates with				
Import. Decisions Residents				.744*
Import. Decision Staff			.448 (PS)*	.780*

Correlated Variables	Managers	Leaders	Direct Care Workers	Non-Direct Care Workers
Import. Decisions Self		.656 (PS)**	.674 (PS)**	
My influence		.639 (PS)**	.734 (PS)**	
My influence/others			.714 (PS)**	.633 (PS)*
Philosophy use		-.500*		
Age				-.714*
Care Subscale PS Correlates with				
Import. Decisions Residents				.604*
Import. Decision Staff				
Import. Decisions Self			.616 (PS)**	
My influence			.639(PS)**	
My influence/others			.501 (PS)*	
Age				-.601*
Import. Decisions Resident (respondent) Correlates with				
Import. Decision Staff	.793**		.747**	.855**
Import. Decision Self			.750**	.811**
Influence			.431*	.611*
Influence/by Others			.521*	
Philosophy Use	.791*		.464*	
Import. Decisions Staff (respondent) Correlates with				

Correlated Variables	Managers	Leaders	Direct Care Workers	Non-Direct Care Workers
Import. Decision Resident	.793**		.747**	.855**
Import. Decisions Staff (PS)				.697 (PS)*
Import. Decision Self	.695*		.516*	.780**
Influence			.674**	
Influence/by others	.597*		.587*	
Philosophy use				.811**
Philosophy use/by others				.727*
Import. Decisions Self (Respondent) Correlates with				
Import. Decisions Resident			.750**	.811**
Import. Decisions Staff	.695*		.516*	.780**
Influence				.670**
Influence by others			.574**	
Philosophy use			.641**	
Tenure		-.495*	.584**	
Import. Decisions Resident (re superior) Correlates with				
Import. Decision Staff	.726 (PS)**		.628 (PS)**	.848 (PS)**
Import. Decisions Self	.656 (PS)*	.554 (PS)*	.749 (PS)**	.953 (PS)**
Influence by others				.638 (PS)*
Philosophy use				.768**
Philosophy use by others				.669*
Age	-.681*			
Import. Decisions Staff (re superior) Correlates with				

Correlated Variables	Managers	Leaders	Direct Care Workers	Non-Direct Care Workers
Import. Decision Resident	.726 (PS)**		.628 (PS)**	.848 (PS)**
Import. Decisions Self		.555 (PS)*	.747 (PS)**	.905 (PS)**
Influence			.478 (PS)*	
Influence by others			.628 (PS)**	
Philosophy use				.757**
Import. Decisions Self (re superior) Correlates with				
Import. Decision Resident	.656 (PS)*	.554 (PS)*	.749 (PS)**	.953 (PS)**
Import. Decision Staff		.555 (PS)*	.747 (PS)**	.905 (PS)**
Influence		.574 (PS)*	.630 (PS)**	
Influence by others			.762 (PS)**	.616 (PS)*
Philosophy use				.672*
Age	-.728**			
Influence (self)Correlates with				
Import. Decision Resident			.431*	.611*
Import. Decision Staff			.674**	
Import. Decision Self				.670**
Influence by others	.864**		.827**	
Age	-.610*			
Influence (seen by others)Correlates with				
Import. Decision Resident			.521*	
Import. Decision Staff	.597*		.587*	

Correlated Variables	Managers	Leaders	Direct Care Workers	Non-Direct Care Workers
Import. Decision Self			.574**	
Influence	.864**		.827**	
Influence re superior (self)Correlates with				
Import. Decision Staff			.478 (PS)*	
Import. Decision Self		.574 (PS)*	.630 (PS)**	
Influence by others	.791 (PS)**	.616 (PS)**	.657 (PS)**	
Philosophy use by others		-.573*		
Age		-.588*		
Influence re superior (seen by others) Correlates with				
Import. Decision Resident				.638 (PS)*
Import. Decision Staff			.628 (PS)**	
Import. Decision Self			.762 (PS)**	.616 (PS)*
Influence	.791 (PS)**	.616 (PS)**	.657 (PS)**	
Age		-.533*		
Philosophy Use Correlates with				
Import. Decision Resident	.791*		.464*	.768 (PS)**
Import. Decision Staff				.811* .757 (PS)**
Import. Decision Self			.641*	.672 (PS)*
Philosophy use by others	.667*	.492*	.565**	.798**
Tenure			.505*	

Correlated Variables	Managers	Leaders	Direct Care Workers	Non-Direct Care Workers
Philosophy Use by Other Correlates with				
Import. Decision Resident				.669 (PS)*
Import. Decision Staff				.727*
Influence		-.573 (PS)*		
Philosophy use	.667*	.492*	.565**	.798**
Tenure				-.762**

**Correlation is significant at the .01 level.* Correlation is significant at the .05 level.

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